HRSA 91-101

4436

COMMUNITY MODEL OF COORDINATION IN PRIMARY CARE PROGRAMS

FINAL REPORT

SUBMITTED TO:

HEALTH RESOURCES AND SERVICES ADMINISTRATION
CONTRACT NUMBER 240-91-0508

SUBMITTED BY:

LEWIN-ICF, INC.
and
MDS ASSOCIATES, INC.

July 29, 1992

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

In an era of constrained resources and increasing demand, coordination among health care providers is increasingly viewed as a way to minimize gaps and duplications in services. Coordinating primary care services among multiple organizations also may be a way to improve service delivery by pooling resources that no organization alone can provide. Health Resources and Services Administration (HRSA)funded agencies and organizations are particularly interested in service coordination since they:

- Are major providers of health care services to vulnerable populations with increasingly complex service demands.
- Have limited financial resources to solve the problems they are addressing.
- Must work with other providers to compete for limited health care professionals.
- May have gaps in their services that can only be closed through collaboration.

This study has two primary goals. First, it is designed to identify those factors within communities that promote primary care coordination and the extent to which those factors are generalizable across communities by asking the following questions:

- What are the unique demographic and political characteristics of the respective communities in which coordinated primary care projects evolved?
- What agencies and organizations are the key players in coordinating primary care service delivery within the respective communities and how are they organized?
- What types of services are coordinated? By whom? With what resources?
- What factors promote collaboration within the respective communities and to what extent are these factors generalizable to other communities?

Second, this study is intended to identify the implications of the findings on future HRSA programs and policies.

To answer the study questions, six communities noted for their model coordination efforts were selected for case studies. Criteria for selecting the sites included a representative geographic mix, both urban and rural sites, and sites with a variety of services and target populations. The study communities were Arrington, Virginia; Hidalgo County, Texas; Albany, New York; Miami, Florida; Chicago, Illinois; and Seattle, Washington.

We developed a framework for the models of coordination that characterizes the coordination efforts within each community. This framework ranges from Discrete Project Models that are less complex coordination models to Systems Integration Models that are more complex:

- **Discrete Project Models** are defined by informal arrangements among participants organized to address specific issues. Participants do not take a global approach to solving its corollary problems across the community. None of the case-study communities are typified by this model as we intentionally analyzed communities with more evolved and complex coordination efforts.

- **Multi-party Interactive Models** are communities in which multiple participants work together on a wide range of projects to address a variety of primary health care needs. While participants may interact on various projects, they do not establish formal organizations to systematically evaluate community-wide health needs and to allocate resources to address those needs. Three of the communities are exemplified by the multi-party interactive model: Arrington, Virginia; Hidalgo County, Texas; and Albany, New York.

- **System Integration Models** are characterized by organizations formally organized into forums that are charged with identifying and addressing the community's broader strategic primary health care issues. While these groups frequently address discrete projects, discussions are often in the context of broader questions addressed by the group such as "what are the community's most pressing primary health care needs and how can we work together to address them?" The case studies that exemplify the system integration model of collaboration include Miami, Chicago, and Seattle.

The exhibit on the following page includes a listing of the sites selected, how they meet the selection criteria, and what model of coordination characterizes their collaborative efforts.

While each community is unique in terms of its geography, demography, health needs, primary care systems, and coordination efforts, the stages that each goes through to develop successful coordination projects include: i j an opportunity for collaboration, or threat to business-as-usual, exists; 2) participating agencies are able to mobilize a successful response to threats and opportunities; and 3) once collaborative efforts are initiated, participating agencies/organizations are able to sustain them.

EXHIBIT 1
SITES SELECTED

SITES	GEOGRAPHIC AREA	RURAL/ URBAN	PRIMARY SERVICE POPULATIONS	HEALTH DEPARTMENT PARTICIPATION	MIX OF HRSA GRANTS	COORDINATION MODEL	HEALTH PROFESSIONS TRAINING PROGRAM
Albany, NY	Northeast	Urban	African-American Hispanic	Yes	Section 330-Community Health	Multi-party Interactive	Yes
Arrington, VA	Mid-Atlantic	Rural	Caucasian	Yes	Section 330-Community Health Rural Health Outreach AHEC Funding Family Practice Residency	Multi-party Interactive	Yes
Chicago, IL	Midwest	Urban	Multi-ethnic	Yes	Section 330-Community Health Section 340-Health Care for the Homeless Ryan White Funding Family Practice Residency	System Integration	Yes
Hidalgo County, TX	South	Rural	Mexican-Americans	Yes	Section 329-Migrant Section 330-Community Health Ryan White Funding AHEC Funding Family Practice Residency	Multi-Party Interactive	Yes
Miami, FL	Southeast	Urban	Latin American Immigrants, Migrant and Seasonal farmworkers	Yes	Section 329-Migrant & seasonal Section 330-Community Health Ryan White Funding AHEC Funding Family Practice Residency	System Integration	Yes
Seattle, WA	Northwest	Urban	Multi-Ethnic including Asian Immigrants and Native Americans	Yes	Section 330-Community Health Section 340-Health Care for the Homeless AHEC Funding Family Practice Residency	System Integration	Yes

All communities face substantial unmet needs, particularly in this era of constrained resources and complex and increasing demands. What distinguishes the case-study communities is not that unmet demands exist but that communities are able to mobilize the responses to meet those demands and sustain efforts once they are developed. Highlights of the factors that characterize successful and sustained collaborative efforts to respond to needs include:

- Strong leaders who instill a top-down commitment to collaboration, promote innovation from the bottom up, inspire a spirit of mutual trust and collaboration, and have a vision for achieving broader delivery-system reform that transcends the needs of their own organizations.

- Ongoing forums for primary care providers to meet and identify local needs and the resources to meet those needs, forums that institutionalize collaboration.

- Staffing and funding resources to meet identified needs.

- Extensive communications and process among all staff to minimize the not insignificant potential for miscommunication and mistrust that could undermine collaborative efforts.

- The ability to view coordination as a whole greater than the sum of its parts.

- Efficient operations that encourage referrals and ongoing use of the services being coordinated.

- Ongoing financial viability for a variety of reasons that might include: coordinated services leverage the staff and resources of existing programs, a critical mass of patients exists, and programs become self-funding or generate new funding when existing funding no longer exists.

Implications of the Study Findings on HRSA Programs and Services.

HRSA was important to the success of many of the coordination efforts analyzed — first by supplying the impetus for their initiation (by providing funding, for example) and second by allowing providers to define their own systems of coordination according to their community's unique needs and operating constraints. HRSA can continue to play that very important role. While quantifiable measures in support of coordination do not readily exist, the testimonials of multiple providers in the case-study communities do.

The four key areas where HRSA can continue to play an important role include:

- HRSA can continue to provide flexible funding oriented toward the development of primary care systems.

- HRSA can provide incentives targeted to promote CHC/health department collaboration.
- HRSA can seek ways to provide longer-term professional assistance to communities about how to develop or enhance existing collaborative efforts.
- HRSA can promote more focused evaluations that include specific criteria and outcomes measures as to what constitutes successful coordination efforts.

CHAPTER I: INTRODUCTION

In an era of constrained resources and growing demand, collaboration among health care providers is increasingly viewed as a way to minimize gaps and duplications in services. Coordinating primary care services among multiple agencies and organizations also may be a way to improve service delivery by pooling resources that no organization alone can provide. The Health Resources and Services Administration (HRSA)funded agencies and organizations are particularly interested in service coordination since they:

- Are major providers of health care services to vulnerable populations with increasingly complex service demands.
- Have limited financial resources to solve the problems they are addressing.
- Must work with other providers to compete for limited health care professionals.
- May have gaps in their services that can only be closed through collaboration.

Some grantees have long coordinated with other agencies. Others have more recently begun to do so, often in response to HRSA's urging and to funding criteria. An example of the latter is the requirement that only one agency per area can be a Section 340 Health Care for the Homeless grantee, which has encouraged the growth of consortia and networks to deal with the severe needs of the homeless.

This study has two primary goals. First, it is designed to identify those factors within communities that promote primary care coordination and the extent to which those factors are generalizable across communities by asking the following questions:

- What are the unique demographic and political characteristics of the respective communities in which coordinated primary care projects evolved?
- What agencies and organizations are the key players in coordinating primary care service delivery within the respective communities and how are they organized?
- What types of services are coordinated? By whom? With what resources?
- What factors promote collaboration within the respective communities and to what extent are these factors generalizable to other communities?

Second, this study is intended to identify the implications of the findings on future HRSA programs and policies.

To answer the study questions, six communities were selected for case studies. In selecting the six sites, our goal was to include a mix of: geographic areas of the country – two rural and four urban sites; service populations including Hispanic, African-American, and non-Hispanic white; different levels of health department participation in coordination efforts; HRSA grantees at each site; sites with more complex coordination both in terms of the number of participants and services; and sites where collaborative projects included primary care training programs.

To develop our initial list of sites for the case studies, we asked HRSA and a number of organizations such as the National Rural Health Association (NRHA), the Association of State and Territorial Health Officers (ASTHO), the National Association of Community Health Centers (NACHC), the National Association of County Health Officers (NACHO) and others to nominate candidates for the study. We received approximately 60 nominations. Projects were screened to assess how they met the selection criteria and then categorized. Projects in Healthy Start cities whose service focus is perinatal care or infant mortality were excluded, since they will be subject to an intense evaluation effort, as were projects without active public health department participation. The remaining 37 sites were eliminated by excluding those with less than two full years of experience in coordinated primary care service delivery. Exhibit I includes a final listing of the sites selected and how they met the criteria for inclusion in the study. This exhibit also includes the coordination model which characterizes each site. These models are described in the next chapter.

Our findings are based primarily on interviews conducted during the site visits. Prior to and following the site visits, data on community demographics and health status indicators were collected in addition to more specific information on participating agency services, target markets, funding, etc.

The site visits were conducted by two senior project team members and ranged from two to three days in length. To ensure consistency, we used standardized interview guides (see Appendix A) across the sites. Interviewees included leaders of participating agencies and organizations, frontline employees, board members, and in some cases representatives from the funding agencies themselves. We also observed the programs in action and, where feasible, interviewed consumer-participants. Most of the interviews were conducted in person. However, where that was not possible, interviews were conducted by telephone.

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This study is intended as an exploratory one to identify factors that promote coordination. As such, it yielded a wealth of information about factors that promote the development of coordination efforts, in addition to those factors that are required to sustain collaboration efforts once they are developed. The case studies findings, however, are actually working hypotheses that bear further study beyond this exploratory project. By design, the present study had:

- Limited sample size.
- No control communities,
- Heavy reliance on qualitative information provided by interviewees rather than more rigorous quantitative analyses.
- No independent evaluation of measures of outcome or impact on cost.

This final report summarizes our findings. More detailed information about each site visit is included in Appendices B through G. The remainder of the report is organized into the following chapters:

- Chapter II — Overview of Models of Coordination and Case Studies
- Chapter III — Factors That Characterize Successful Coordination Efforts
- Chapter IV — Implications for HRSA

/CHAPTER II: OVERVIEW OF MODELS OF COORDINATION AND CASE STUDIES

We have developed a framework which defines coordination efforts by the number of services they include and their strategic focus. The framework classifies three basic models of coordination which, ranging from simple to more complex, include:

- Discrete Project Model.
- Multi-party Interactive Model.
- System Integration Model.

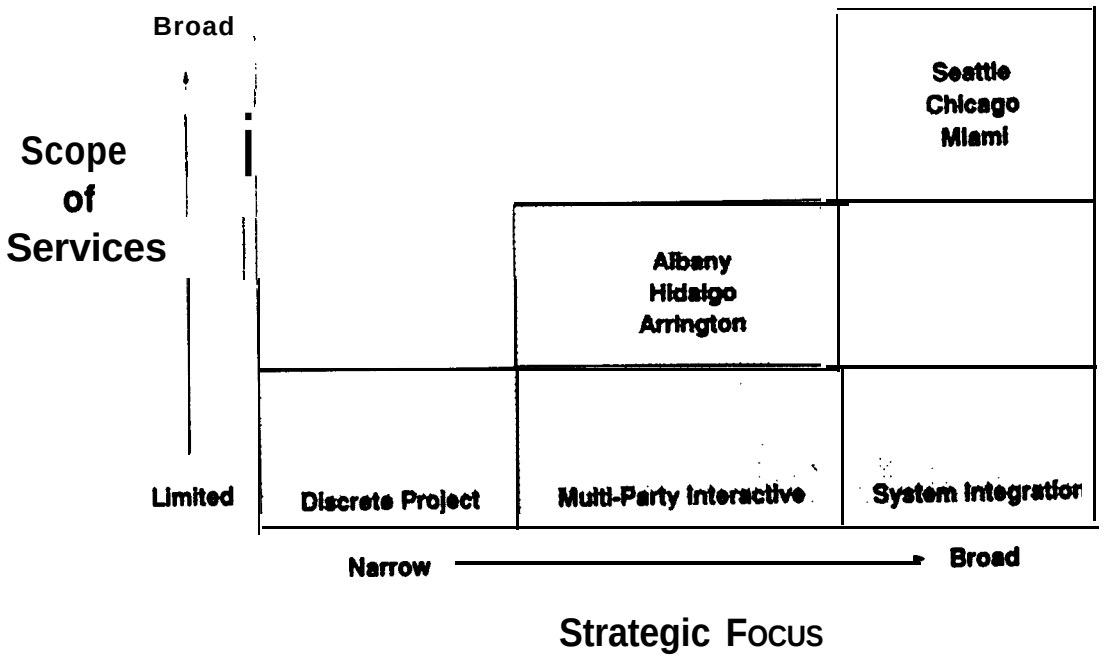
Since the case studies include well-developed models of coordination, none are represented by the less complex Discrete Project Model. Of the six sites, three (Albany, NY; Hidalgo County, TX; and Arrington, VA), are typified by the Multi-party Interactive Model, and three (Seattle, Chicago, and Miami), by the System Integration Model. This chapter details the models of coordination and how each of the case studies fit, within it.

In developing the framework for classifying coordination efforts, we define coordination by two basic dimensions: 1) the scope of health care services addressed by collaborative efforts, and 2) the breadth of the strategic focus of collaborative efforts. (See Exhibit 2.1 on the next page.) The vertical axis of the graphic represents the **scope of services** addressed by collaborative efforts, the horizontal the strategic focus.

The **scope of services** provided through collaborative projects, represented on the vertical axis, may range from limited to broad. A coordination project whose scope is narrow may focus on one aspect of a single issue. For example, collaboration may address maternal and child health needs with an immunization program in which one agency purchases vaccinations and supplies them to a second agency to be administered to patients. This project is relatively limited in service focus. A broader service focus might include vaccinations as part of a larger program to address maternal and child health that also includes collaboration to provide iinkages for well-baby care, perinatal substance abuse, specialty pediatric services and case management.

The strategic **focus,** represented on the horizontal axis, may also range from narrow to broad. A narrow strategic focus would be characterized by a coordination effort that is organized to address an easily defined and discrete project. For example, it might include an agreement between a health department and a nearby community health center that the health department would refer patients from its family planning clinic to the CHC for comprehensive services. A broader strategic focus might include a project that is designed to address AIDS-related problems in the community by estimating the demand for AIDS related services within a community, identifying projected health and social services needs, and developing a plan to meet those needs.

MODELS OF COORDINATION



A broader strategic focus would more typically be characterized by more formal agreements and organizational relationships (for instance, an oversight board might exist) and more agency participants. A more limited strategic focus might typically be characterized by more informal agreements among fewer participating agencies. It is reasonable to expect that, the more services rendered through a particular collaborative agreement, the broader the strategic focus of that collaboration is likely to be.

As illustrated in the exhibit above we have clustered the models into three primary types of coordination models: the **Discrete Project Model,** the **Multi-Party Interactive Model,** and the **System Integration Model.** Discrete project models at one end of the continuum represent singular, isolated efforts at collaboration that are limited in their strategic focus. System Integration Models at the opposite end of the continuum represent more integrated systems of primary care service delivery. Multi-party Interactive models are characterized by collaborative efforts that have evolved from discrete projects and have begun to look at broader systems issues. The three different models are described in greater detail below.

A community can generally be categorized by the most developed type. of coordination model within it. In a community where projects are limited to those that involve few participants who collaborate on discrete issues, coordination for the community as a whole can be characterized by the Discrete Project Model. As coordination projects become more complex, that is, as they are organized to address the broader needs of the community, then a community moves from a discrete project orientation to a system orientation.

Discrete Project Model

At the least complex end of the organizational relationship spectrum, the Discrete Project Model is characterized by fewer participants working together on discrete projects. Participating agencies otherwise remain autonomous and do not overlap organizationally or financially. In addition, discrete model projects are organized to address specific issues and do not take a global approach to solving its corollary problems across the community.

The linkages from which these projects originate may either be informal, based on mutual consent or verbal agreements, or formal, arranged by contract or a common grant. Under the Discrete Project Model, informal agreements predominate, as they are often based on more familiar day-to-day operating relationships and require a lesser commitment of resources. Discrete projects often involve only two agencies, although they may include more. Formal directorates are not necessarily required to oversee these projects. Administration is simple: if management is required at all, one agency often takes the lead management role. Although agencies may collaborate on more than one project, these projects, like the agencies that sponsor them, are conducted independently of each other and are, thus, easily distinguished from one another.

The Discrete Project Model is a starting point from which communities often develop more intricate models of collaboration, Collaboration over discrete projects may lead to the mutual trust and cooperative spirit required to develop more complex relationships because they provide opportunities for individuals to get to know each other.

An example of a discrete project is the CHAMP Day project at Albany's Whitney M. Young Health Center. On CHAMP Day, the center coordinates a health fair at a neighboring grade school with the participation of other area health care and social service agencies featuring carnival booths that are both enjoyable and educational for students and their families. The health center initiated this project to increase health awareness among families and improve the image of health organizations in the community. As a discrete project, CHAMP Day is not characterized as an effort by the parties to meet on an ongoing basis to ameliorate pediatric health problems.

The example is, however, further illustrative of how a discrete project may evolve in scope. Based in part on collaboration between the Whitney Young Health Center and the Arbor Hill Elementary School, these organizations have collaborated to obtain a New York state grant to turn Arbor Hill into a "Community School," which offers extended health and social services to students, including augmented extra-curricular activities.

None of the six sites that we visited can be categorized by Discrete Project Models of coordination. This is a result of the site-selection criteria, which by design specified sites in which a multitude of participant agencies work together to address a broad range of health issues. That our study does not include any Discrete Project Model communities should not imply that successful coordination cannot be achieved with this model. Although a project-by-project orientation may be considered a stepping stone towards more integrated service delivery, for smaller, less complex communities this model may be an efficient way to maximize resources if those models, though discrete, indirectly address the community's broader needs. The larger number of health and social service providers and more complex needs of larger communities often dictate more formal relationships and more coordinated planning to address broader community needs.

Multi-Party Interactive Model

Farther along the continuum of organizational relationship complexity is the **Multi-Party Interactive Model.** It contains elements of both other models but is distinct as it involves more than coordination over discrete projects but less than integrated systems of operation that are characterized by interlocking directorates and community-wide needs assessment and planning. Communities characterized by this model include multiple participants who work together on a wide range of projects to address multiple health care needs. While participants may interact on various projects, they do not establish formal organizations to systematically evaluate community-wide health needs and to allocate resources to address those needs.

Project coordination in this model may be informal or formal. Grants are often funneled through one agency that solicits the political and resource support of collaborating organizations. Similar to the Discrete Project Model, collaboration projects in the Multi-Party Model may be unrelated to each other; they do not involve centralized planning for the community. Within the context of a multi-party interactive approach, organizations may create a consortium to oversee certain aspects of the health care system, but they do not unite under one or more umbrella groups to examine the broader issues of the community's health care needs and delivery systems.

An example of multiple parties collaborating to address multiple components of a health care issue is provided by an effort in Arrington, Virginia. The Blue Ridge Medical Center (CHC), the local Nelson County Department of Public Health, Martha Jefferson Hospital, and a nearby medical center of the University of Virginia. contribute to maternal and child health services in the region based on their resources and particular expertise. Both Blue Ridge and the health department provide some prenatal and child care. Blue Ridge often refers indigent patients to the health department for immunizations, WIC, and family planning; conversely, the health department refers to Blue Ridge for more comprehensive primary care. Each of these refers, as appropriate, women with insurance to Virginia Baptist, and indigent women to the University of Virginia. Each participant in this coordination effort supplies some resources to address broad maternal/child health service needs.

This example may be used to illustrate how a program can evolve from a discrete project into a multi-party approach. Collaboration may begin with a simple referral

relationship, such as a health center sending its WIC patients to the local public health department. After arranging WIC services, the parties may become more familiar with one another's services and start coordinating services along other dimensions as well. For example, the health department may begin to look to the health center for pediatric services to supplement health department well baby clinics. In similar fashion, other health care agencies may be brought into the coordination effort, which therefore expands in organizational complexity and the scope of services that it provides.

Based on our site visits, we classify Arrington, Virginia; Hidalgo County, Texas; and Albany, New York as implementing a Multi-Party Interactive approach to primary care coordination, We will describe each of these sites, including how they fit into the Multi-party Interactive Model, later in this chapter.

System Integration Model

Models of system integration are characterized by participating organizations that are formally organized into one or more forums to identify and address the community's broader strategic primary health care issues. Forum participants often include the leaders of the participating agencies themselves. While these groups frequently discuss discrete projects, these discussions are often in the context of broader questions addressed by the group such as 'what are the community's most pressing primary health care needs and how can we work together to address them?"

The participating agencies are often highly integrated organizationally and programmatically. Efforts by these groups are more often driven by formal needs assessments and access to a wider range of resources. Unlike programs conducted under the Discrete Project Model, ownership of a particular coordination effort may be difficult to identify.

Miami is an example of a community characterized by a System Integration Model. In Miami, the Primary Health Care Consortium of Dade County is an independent body created by and including representation from all major players in the primary health care community in South Florida. The Consortium meets regularly to refine and introduce coordination projects and oversee health planning for the community. The programs that the Consortium developed to facilitate patient referral typify this system-wide approach to primary care. Based on group discussions that resulted in a county-wide health strategy plan, community health centers, the department of health, and Jackson Memorial Hospital (the local public hospital) agreed to establish common criteria for patient eligibility in Miami's indigent care system. Under this program, patients who register at any primary care clinic are automatically eligible for services at all primary care clinics and for public hospital inpatient care. To further facilitate patient care, the Consortium has worked with the hospital to install hospital computers in the primary care clinics to allow for reciprocal scheduling of patients for appointments at Jackson's specialty clinics and at the community health centers for primary care. Both of these programs were identified and carried out to improve efficient access to care for indigents based on the county's urban strategy plan.

Based on our site visits, we classify Miami/Dade County, Florida; Chicago/Cook County, Illinois; and Seattle, Washington as implementing a System Integration approach. In the six sites we visited, models of System integration are characteristic of the three largest and most complex communities, while the Multi-Party Interactive model is characteristic of the three smaller communities, This tendency toward system integration in the larger communities has two components: 1) the larger communities in the study are confronted with a wider array of complex health issues involving a larger number of providers. Ensuring that needs are met and duplication is eliminated requires more system-wide coordination and strategic planning; 2) the presence in large communities of (often-specialized) health agencies requires more oversight to coordinate their efforts, More recently, the less formal, more discrete multi-party models of the smaller communities we visited have been evolving towards more organized planning efforts as their needs have become increasingly complex.

The type of coordination model that characterizes a community might also be dictated by that community's political, legal or funding constraints on the ability of organizations to work together. These constraints may make it infeasible for a community's coordination efforts to evolve from one stage to the next.

We present these models of coordination as a resource to aid in thinking about coordination; they are not intended to serve as a map for program design. The models do not suggest proper organizational structures, necessary programs: or appropriate program components. Unique local resources, political dynamics, and operating constraints determine the most appropriate models for coordinating services.

2.1 **Case Studies**

As we have previously discussed, each of the sites we visited is typified by either the Multi-party Interactive or the System Integration Model of collaboration. Albany, New York; Hidalgo County, Texas; and Arrington, Virginia are characterized by the Multi-party Interactive Model and Chicago, Miami, and Seattle, by the System Integration Model.

Those typified by the Multi-party Interactive Model communities are characterized by collaboration among multiple participants to address particular issues from a broad range of heaith and social service needs. These participants are not organized to address wider primary care delivery system issues of their communities, for example -- What are the community's existing primary care service needs? What resources should be organized to address them? By whom? Rather they are organized to address multiple issues within their communities, as opposed to undertaking fundamental reforms of or reorganizations within those systems. In contrast, the three sites that employ System Integration Models are characterized by forums organized to identify and address broader community primary health care needs, These forums included representation from many of their community's primary health care providers.

Each of the communities is unique in terms of its geography, demography, health needs, primary care systems, and coordination efforts. Lengthy case study reports for each site visit are included in Appendices B through G. These individual case study reports provide detailed descriptions of the respective communities, key providers of primary care to

the indigent, participating agencies and their coordination efforts, and factors that promoted successful collaboration in those communities. In this section, we provide an overview of each of the communities, the general characteristics of their coordination efforts, and a summary of the key factors that led to the development and success of their respective coordination efforts. The sites are presented in order of increasing complexity in the organization and delivery of primary health care services. The communities that typify multi-party interactive models are described first, followed by those that typify system integration models.

2.2 Multi-party Interactive Models

The three communities that we classed as multi-party interactive models in order of increasing complexity include: Arrington, Virginia; Hidalgo County, Texas, and Albany, New York. In all these communities, multiple agencies and organizations are highly interactive and commonly work together to eliminate service gaps and enhance existing services. Participating groups have a long history of working together and view collaboration as a way to create a whole that is greater than the sum of its parts. These communities are alike in that none have organized systems or consortia of providers designed to rethink the fundamental organization of primary care delivery systems. The consortia that do exist address more defined problems, such as how to decrease the incidence of AIDS.

Arrington, Virginia

The rural, central Virginia region surrounding Arrington is characterized by a low population density and lack of health care providers. In Arrington the Blue Ridge Medical Center (CHC), is the lead agency that coordinates primary care services. Blue Ridge is a relatively new CHC established in 1986, when a group of community leaders coalesced to apply for a Section 330 grant. It is the major provider of care to all socio-economic strata of the population. This is unique among the sites we visited, the rest of which primarily serve indigent populations. The population of Arrington and Nelson County nonetheless contains a high percentage of impoverished residents, many of whom are elderly. Approximately three-fourths of the center's users are non-Hispanic whites; one-fourth are African-American; and one percent are Hispanic.

Outside the schools and medical residency programs that participate through the AHEC and the health department, most of the other agencies and organizations that participate in local coordination efforts are small, consisting of a core of two to three individuals, many of whom have been active in those positions for over a decade. As a rural community, staff from various agencies are familiar with the services provided across providers and often socialize with other agencies' staff members.

Coordination efforts in Nelson county are historically typified by a Multi-Party Interactive approach. The projects are organized to facilitate referrals across agencies for a multitude of services. Organizational relationships are largely informal and lack an oversight body formally organized to manage those efforts or measure their impact. More recently, coordination is becoming more formal as a result of a new Rural Health Outreach Grant that Blue Ridge administers. The more formal organization is in part due to the grantor's requiring

more oversight and outcomes monitoring by the various participating agencies. It is also due to the new infusion of funds and concomitant staff requiring more independent tracking.

The new Rural Health Outreach grant is promoting more systemic and organized reviews of the county's primary care service needs and ways to address them. Nonetheless, these are more focused reviews that, unlike System integrated Models, do not involve more systemic reviews by multi-agency consortia organized to address broader system issues such as the organization and allocation of resources across Nelson County's primary care delivery system.

The major factor precipitating collaboration in Arrington, as in the rest of the case studies, is unmet community need and limited health resources available to meet those needs, In addition, factors promoting collaboration in Arrington include:

- Many of the other community health centers we visited had boards that included members of participating agencies and organizations. However, Arrington is unusual in that Blue Ridge's bylaws require a board seat for a local health department representative. In addition, all of the local participating agencies are represented either on the board itself or on one of the board's numerous active subcommittees. This broad representation on the health center's board creates a forum for collaboration that might not otherwise exist.

- To promote collaboration, many of the larger communities relied on multiple consortia to facilitate working relationships. In Arrington, most of the staff across the participating agencies are home grown and are familiar with one another, with the services their respective organizations provide, and how to access them. This facilitates collaboration and minimizes mistrust. In addition, they are often familiar with the clientele they serve.

Hidalgo County, Texas

The most salient community features and health care needs of Hidalgo County, Texas are dictated by the county's proximity to the United States-Mexico border. The county is largely Hispanic, almost exclusively Mexican-American, and contains a high proportion of young residents. The county is mainly rural and, although it contains small pockets of industrialization, relies primarily on retail trade (especially from Mexico) and agriculture for income and employment. The challenging health problems of the community include health care for the large number of migrant and seasonal farmworkers, many of which inhabit geographically isolated, dilapidated clusters of dwellings called "colonias".

The Hidalgo County Health Care Corporation (HCHC) is the lead agency for the majority of coordination projects in the area. Incorporated in 1973, the corporation consists of four Section 329 and Section 330 funded Community Health Centers, which offer comprehensive primary care services to the migrant and seasonal farmworkers and other indigent residents. The Health Care Corporation coordinates its programs with the Hidalgo County Health Department, which provides a range of categorical clinic services: the McAllen Medical Center, the largest and most centrally located hospital to HCHC clinics; Planned

Parenthood of Hidalgo County; the University of Texas Health Sciences Center; Valley AIDS Council; and Lower Rio Grande Valley Area Health Education Center.

Typical of communities represented by the Multi-party Interactive approach, coordination programs in Hidalgo County generally address specific issues and services. Over time Hidalgo County has moved toward more system-wide collaboration but, unlike the communities characterized by a System Integration Model, providers in Hidalgo County are not organized to actualize their combined vision of a more integrated and coordinated primary care delivery system. An example of a typical program organized by multiple parties to deliver specific services is the cervical dysplasia clinic organized by a consortium of local agencies, including the HCHC, county health department, and Planned Parenthood to provide cervical cancer screening to low income women in the area.

Several factors promote collaboration in Hidalgo County:

- A real sense of community pride and identity exists in Hidalgo County's largely Hispanic community that promotes coordination. Participants view collaboration as an important way to meet the health care needs of Hidalgo County that otherwise might go unmet. Direct care givers are often from the community and are vested in its welfare. They view the community health center as an integral and vital part of that welfare.

- While AHECs play an important role in driving coordination efforts in many of the case studies, the role of the AHEC was particularly important to Hidalgo County's collaborative efforts, The University of Texas' research facilities, medical schools, and funding sources promote the staffing, training, and service delivery programs that otherwise might not exist. The University of Texas has recently developed a border health coordination project to more systematically assess South Texas health care needs and to work with local communities in designing research projects and delivery systems to address them.

- And finally, a key factor is strong leadership of the Hidalgo County Community Health Centers, of the University of Texas, and of the local health department. These leaders have strong training and expertise, are respected internally and externally and promote a sense of trust and communication that is vital to ensuring the success of the efforts. For example, the leader of the Hidalgo County Community Health Care Center is active on national committees organized to address Hispanic healthcare issues and is a frequent speaker locally and nationally on related issues.

Albany, New York

Albany, New York is an area plagued by health and economic problems endemic to urban environments. Lack of prenatal care, teenage pregnancy, substance abuse, AIDS, and communicable diseases are particular problems in Albany. Due to the age of many buildings, lead poisoning is also an issue for many youths. While the population of Albany county and

city is primarily non-Hispanic, the indigent community in the city's Northside, where the main agency we visited is located, is characterized by a higher proportion of African-Americans, Hispanics and members of other ethnic minorities.

The lead agency for many of Albany's coordination efforts is the Whitney M. Young Health Center. The Health Center has evolved since 1971 to offer comprehensive primary care services and additional social service outreach programs. Supported by a Section 330 grant among other funding, Whitney M. Young is the principal source of primary care for indigent patients in the north sections of Albany. The Albany County Department of Health is also active in primary care; its comprehensive clinic serves the city's Southside. St. Peter's Hospital, Albany Medical Center, the New York State Department of Health, Arbor Hill Elementary School, and a host of area housing and social service agencies also collaborate on various projects.

As is typical of case studies characterized by Multi-party Interactive Models, Albany's coordination projects are generally less formal and involve multiple participants organized to address specific health care issues. Key among collaborative efforts are substance abuse and maternal and child health programs that integrate the health, social and housing services of a multitude of agencies, No unifying consortia exist to routinely assess system-wide community primary health care needs. An example of program-specific coordination efforts is the Family Alcoholism and Chemical Treatment Services (FACTS) 'program, which approaches alcoholism and drug addiction treatment from a holistic perspective, addressing the multiple and complex related health and social service needs of these patients, The Health Center provides primary counseling and health services; St. Peter's Addictions Recovery Center is used for inpatient services; Albany County Substance Abuse Clinics provide mental health evaluations; other agencies, such as St. Joseph's Housing Coalition, provide living facilities; social service groups support re-entry to the patient's re-entry to socialization; and still other agencies promote education and nursery services.

Several factors were critical to the development of successful collaborative efforts in Albany:

- Although the Whitney Young Health Center has historically been characterized by successful collaboration, particularly around alcohol and substance and drug abuse programs, external and internal constituents alike repeatedly asserted that a critical juncture was the recruitment of a new center director in the late 1980s. Since that time, coordination efforts have increased exponentially. The success of this strong leader was attributed to her training and expertise, her enthusiasm for bottom-up inspired efforts, her willingness to encourage risk taking, and her ability to look beyond the interests of her own agency to the broader interests of the community.

- Unique among the communities we visited were state-sponsored integrated health, social and housing initiatives. The resultant integrated health, social and housing programs begun in response to these initiatives are a testimony to the role state funding can play in the development of coordinated care, This funding is in part contingent on evidence that collaboration across agencies takes place.

- And finally, a critical mass of patients is present to support specific programs, warranting funding support for problems that may go unaddressed in smaller communities.

2.3 Systems Integration Models

The communities characterized by systems integration models, in order of increasing complexity, are Miami/Dade County, Chicago, and Seattle. While the lead agencies in these communities vary somewhat, all the communities are similar in that they have multiple forums organized to address fundamental delivery system issues. In each of the communities, a shared vision exists of what the delivery system should look like. In addition, all the major providers work together through these forums to analyze the delivery system and to identify the best way to combine resources to address health needs.

Miami/Dade County, *Florida*

Dade County houses nearly two million residents. The closest American port city to Latin America, it has expanded rapidly over the past decade to accommodate influxes of immigrants. Dade County is striking in the diversity of its geography, residents, and economy. The southern end of the county is rural and supports agriculture, while the majority of the county is urban and suburban and supports international trade, tourism, and industry. Nearly 50 percent of residents claim Hispanic ethnicity, including Cubans, Central Americans, and other nationalities. Haitian immigrants are also a sizable minority. Some 20 percent of residents are African-American, As immigrants have settled in Dade County, they have often chosen to reside near other immigrants of their nationality. The special health needs of Dade County include prenatal care, AIDS services, and substance abuse prevention and treatment and the particular problems experienced by the migrant and seasonal farmworkers.

As we witnessed in other communities characterized by the Systems Integration Model, coordination efforts are led by the Public Health Trust, a governing body whose lead agency is Jackson Memorial Hospital, and the Primary Health Care Consortium of Dade County. Both exist for the explicit purpose of planning and coordinating services among the various components of the Dade County primary care system and include the county's major primary health care providers. For example, in the mid-1980s the Primary Health Care Consortium created an urban strategy plan that included a list of community-wide health care priorities and an action plan for addressing them. In addition, the plan established county-wide standards for patient eligibility, and an integrated computer network with terminals placed in various community health centers and health department clinics that facilitates cross-scheduling, access to hospital ancillary test results, and each clinic's capacity to determine if patients keep follow-up appointments.

These two consortia take the lead role in shaping the community's primary care delivery system. The health department in Dade county participates in these consortia but does not take the lead in identifying and planning for more system-wide reform.

The bases for Dade County's successful coordinative programs are multi-factorial:

- The beginnings of Dade County's system-wide collaborative efforts can be traced to National Health Service Corps (NHSC) resources. HRSA made it clear that, to receive NHSC health professionals, the seemingly disparate forces among the community's primary health care providers would have to be unified to address system-wide primary health care needs. As a result, participating agencies combined forces to develop an urban strategy report. This effort provided evidence that participants could indeed work together to obtain more for the community than any one organization could provide. This evidence promoted a willingness to continue working together on a variety of other delivery system issues.

- Proactive leadership by the local public hospital is also instrumental to the success of coordinated efforts in Dade County. This leadership has led to more integration between the services of the hospital and those of the community health centers than typically exists in many communities where hospitals have historically focussed on inpatient care. Many hospitals are just now, if at all, looking to ways to better direct services from emergency rooms to community-based systems of primary care.

- Collaboration is also aided by the fact that the health department relies on the community health centers which are widely dispersed as a ready-made distribution network for health department programs and services. For example, the health department provides free serum for immunizations and looks to the community health centers as effective distribution networks.

Chicago/Cook County, Illinois

Chicago is a large and racially diverse city whose three million inhabitants live in 75 identifiable neighborhoods, each of which could be considered its own community. Cook County, which includes an additional two million inhabitants, surrounds the city and is also considered in this case study. The area's political dynamics, large urban population, and concomitant health problems pose profound challenges for the health care system.

The county's system of primary care to the indigent consists of a system of numerous Chicago Department of Health comprehensive, neighborhood-oriented health centers; Cook County Department of Public Health clinics; federally funded Community Health Centers; and Cook County Hospital and other outpatient clinics. These providers acknowledge that they operated for years without concerted collaborative efforts, which resulted in glaring gaps and inefficiencies within the system. Efforts at service coordination have begun in recent years to ameliorate these inefficiencies. In addition to the organizations mentioned above, the Illinois Primary Health Care Association, Cook County Bureau of Health Services, Chicago Community Trust, and other government, health, social service, and teaching organizations contribute to coordination efforts.

The Chicago/Cook County model of coordination characterizes that of a System Integration approach with a top-down perspective. In response to the growing health care crisis in the region, health agencies united in 1989 at the Chicago and Cook County "Health Care Summit" whose extensive activities and recommendations included the recognition that the system of primary indigent care could improve its efficiency through expanded coordination, The task force recognized the need for integrated programming among large, often bureaucratic organizations. Numerous projects have since been established for this purpose. An example is the Health Care Linkage Project, operated by the Illinois Primary Health Care Association using Chicago Community Trust funding. This project began by establishing formal patient referral linkages among Chicago Department of Health Clinics and Community Health Centers and has expanded to implement intricate plans to improve indigent access, care quality, and system inefficiency. Other programs, such as the Neighborhood Referral Project and Ambulatory Care Council, also work to better integrate the county's primary care. These independent organizations of participating agencies provide more neutral forums than traditional health agencies for addressing historical barriers to coordination, such as territorial disputes.

Unique factors which promote successful coordination in Chicago include many projects' orientation towards self-examination. The inclusion of federal and state authorities in planning coordination projects aids both in their design and their ability to attract funding.

- Particularly important to the success of recent coordination efforts in Chicago is the establishment of neutral forums to facilitate cross-system collaboration in an environment that historically has been highly politicized.

- Participants in Chicago, recognizing the major hurdles to be overcome, developed more systematic community plans for achieving primary care delivery system reform. Unlike programs in other sites, Chicago's plans include more formal evaluative measures against which to gauge their successes in addressing issues.

- Although a history of collaboration and joint ventures contributes to successful coordination in other communities, in Chicago this tradition has not existed. Therefore, particularly important to the success of Chicago's efforts is a new willingness and commitment to work together by Chicago's healthcare leaders. Without this top-down commitment and concomitant effort this reform could not be achieved.

Seattle, **Washington**

The 500,000-resident city of Seattle is distinguished by its geography and population diversity. The most populated region in the Pacific Northwest is divided irregularly by natural water and hilly barriers. Nearly half of the users of the city's primary indigent care system are non-Hispanic whites; nearly one-fourth are American Indian or Alaska Natives; African-Americans, Hispanics, and Asian/Pacific Islanders each comprise about 10 percent. Unlike Miami's ethnic groups, the minority populations in Seattle are not clustered into neighborhoods.

Consistent with a Systems Integration Model, many consortia exist in Seattle to address Seattle's primary health care needs. Key among them is the Central Seattle Community Health Centers (CSCHC), which consists of five member community health centers and embraces the Seattle King County Health Department.

The CSCHC was originally organized to develop a system-wide plan for deploying National Health Service Corps physicians, Its many committees of providers now serve as institutionalized forums for many community health care providers to meet around broader systems delivery issues. For example, a medical directors' subcommittee of the consortium meets monthly. The subcommittee includes physicians both from CSCHC member clinics and other community health care providers as well. Among other things, these forums are used by physicians to identify ways to work together to promote more comprehensive medical care and physician cross-coverage. The CSCHC serves as a conduit for federal funds for its autonomously organized and governed member clinics. In addition, the CSCHC houses several coordinated efforts of its own, including medical interpretation services and a Sound Heart Program that provides high-risk screening for cardiac-related factors.

More so than any of the health departments in the previous case studies, the Seattle-King County Health Department has a long history as an active leader in shaping local primary care delivery systems. It is a major funder of local primary care services, including community health center services. It has traditionally leveraged this funding to accomplish its broader system plans. For example, where the health department was concerned about the ongoing financial viability of a small community health center, it threatened to withdraw center funding unless the center merged with a larger and more viable community health center.

The Department has historically provided its own categorical health services but has recently expanded its service base to include more comprehensive primary care services as well. This creates a unique position for the health department as both a funder and competitor of community health centers. Potential friction is mitigated by a history of collaboration between the health department and community health centers. Collaboration has become institutionalized. As community health needs are so extensive in Seattle, there is plenty of work for everyone.

As in other Systems Integrated Model sites, coordination projects in Seattle are characterized by formai agreements as well as the formal consortia organized to facilitate them. In addition to the more formal collaborative efforts, the community health centers themselves act as free agents in developing a myriad of referral relationships among other primary care providers. Interviewees related that their capacity to develop these health center-specific relationships independently creates much needed flexibility to respond to their own unique needs.

The success of Seattle's coordination efforts is dependent on many factors. Key among them are the following:

- A vision of system-wide integrated service delivery was promoted by an activist mayor of Seattle who led the community in organizing providers to addressed service delivery issues. His interest in service delivery issues was fueled by a key advisor who was previously a director of a local community health center.

- Local business and foundation funding has been important to the development of collaborative efforts in Seattle, For example, in the early 1980s the local United Way funded an effort among all of the community's major primary care service providers to address how the community should respond to major pending cuts in federal health care programs. United Way resources were used to identify what the impact of the cuts would be, to help participants more rationally reallocate services to respond to those cuts.

- National Health Service Corps resources precipitated the first system-wide collaborative effort among community health centers. To obtain NHSC physicians, community health centers worked together to conduct an organized assessment of the community's primary health care needs and to develop a plan to respond to those needs.

- In Seattle, more so than in other case study communities, primary care service providers have a long history of working with one another that has led to the institutionalization of collaboration. Formal oversight bodies are less important to ensuring that this collaboration takes place than they might otherwise be in communities without a similar tradition of collaboration.

CHAPTER III: FACTORS THAT CHARACTERIZE SUCCESSFUL COORDINATION EFFORTS

In each of the case studies -whether systemic or integrated models, urban or rural, large or small — successful collaboration is characterized by the following three stages:

- First, an opportunity for coordination, or threat to business-as-usual, exists.
- Second, participating agencies are able to mobilize a successful response to the opportunity.
- Third, once coordinative efforts are initiated, participating agencies/organizations are able to sustain them.

Many of the factors that characterized these stages are common to all of the sites. In other cases, they are more characteristic of larger or, conversely, smaller coordinative efforts.

3.1 An Opportunity for Coordination, or Threat to Business-As-Usual, Exists

Many of the opportunities for coordination exist because of circumstances external to the participating agencies themselves. For example, the availability of new federal or state funds provides opportunities for collaboration. Less frequently, opportunities exist because of factors unique to a participating agency or organization. For example, a new leader with a historical interest in affiliations with institutions of higher learning is recruited. Threats to business-as-usual provided opportunities as well. For example, major pending cuts in federal health care spending led Seattle's primary care providers to collaborate around initiatives to respond to those cuts. The opportunities and threats that commonly precipitate collaborative efforts are described in more detail below. They include:

- Unmet needs.
- National, state and local initiatives.
- Community leadership.
- Pre-existing networks.
- New staff with different ideas/new expertise.

Unmet **Needs**

A major factor cited by all participants is the existence of unmet needs because demands for primary health care services are increasing and becoming more complex at a time when resources were diminishing. The positive politics of scarcity is a factor promoting coordination across all of the case studies. No one organization can meet all of the demands that exist.

Many of the communities related that demands on delivery systems are increasing as a result of the AIDS, crack users, and homeless populations. Interviewees cited several examples of how the needs of these populations cannot be met without collaboration. For example, Albany's Whitney Young Health Center provides outpatient programs for substance abusers and collaborates with an area hospital to develop integrated outpatient and inpatient programs. Where more sophisticated planning systems exist, as in Chicago, these needs are identified through more formal and collaborative needs assessments. More often needs are recognized informally, for example, by clinic workers who in their day-to-day work have difficulty obtaining needed referral sources.

National, **State, *and Local initiatives***

New **national initiatives** present major opportunities for coordination for all six communities. Key among them was legislation in the mid-eighties that made urban areas eligible to apply for National Health Service Corps (NHSC) physicians. In two cases, Miami and Seattle, NHSC legislation was particularly important in precipitating more system-wide collaboration, where previously collaborative projects had been more discrete. CHCs within these communities joined forces to apply for NHSC placements because they understood that joint applications that integrated the broader needs and resources within community would be favored over single-agency applications. In Miami Bureau of Primary Health Care (BPHC) was instrumental in supplying the technical support required to apply for NHSC physicians.

Funding for Area Health Education Centers (AHECS) also was an important instigator of more system-wide coordination in four of the six sites: Seattle, Hidalgo County, Miami, and Arrington. In these sites AHEC funding promoted new collaborative efforts between educational institutions and primary care providers. Educational institutions view AHECs as a way to create more community primary care training opportunities, increasingly required by accrediting agencies. Community clinics see AHECs as valuable ways to generate additional clinical support (from trainees rotating through clinics), enhance training programs, recruit new physicians, and retain existing ones (who find potential AHEC- related faculty appointments attractive).

Collaboration is also often promoted at the national level by organizations that accredit educational programs including medical residency programs and schools of nursing, medicine and public health because these organizations increasingly require that students, as part of their training, rotate through community programs. For example, the American Council on Graduate Medical Education has promoted collaboration between medical schools and community health centers by placing increasing emphasis on ambulatory care training

opportunities. In Albany a requirement that the local school of public health provide community training programs precipitated collaboration between the school and the Whitney Young Health Center. Whitney Young's medical director was appointed to the school's faculty and students from the school could elect to rotate through the center.

New **state initiatives** also present opportunities for coordination. For example, in Texas state funding for children with disabling illnesses provides needed resources that help Hidalgo County support pediatric clinical programs. New York State's progressive funding for integrated housing and service programs promotes the development of collaborative programs in Albany.

In some instances, coordination results from **local initiatives,** for example, local business or not-for-profit agency support, for example, in Seattle the United Way funded a collaborative effort designed to identify ways for organizations to work together to respond to system-wide cuts in federal health care programs. If this funding had not existed, participating organizations may not have had the resources required to identify and prioritize ways to respond to the cuts.

In some instances regulators mandate collaboration. For example, in Seattle, a local hospital's certificate of need to expand its bed capacity was contingent on the hospital's agreeing to make more beds available to indigent obstetrical patients. This precipitated collaboration between the community health centers and the hospital to better coordinate obstetrical services. Many examples were provided of collaborative efforts that developed because they were required by potential grantors (at the state, national, and local level) whose awards were contingent on evidence of interagency collaboration. These grantors look to collaboration as a way to expand limited resources. For example, HRSA requirements were key to the development of formal consortia in Arrington (Rural Health Outreach Grant) and in Hidalgo County (AIDS project).

Community ***Leadership***

All case study communities are fortunate to have leaders who are major proponents of health care delivery reform that includes collaboration among health care providers to make more efficient use of limited resources. In smaller communities, leadership is often vested in one or two key individuals. In more sizable communities, a larger critical mass of leaders is required, particularly to generate opportunities for more system-wide collaboration. Effective leaders are characterized by their ability to bring together a diverse group of participants (often with conflicting interests) to identify and address broader community needs, For example, in Seattle many of the more system-wide opportunities for collaboration were introduced when a new activist mayor developed coalitions of leaders. One of the mayor's major goals was to reform Seattle's primary health care delivery system by building coalitions of leaders (among community health centers, the health department and other primary care providers) to address delivery system reform.

New collaborative efforts were also identified when leaders of organizations who were less enthusiastic about collaboration left and were replaced by new, more enthusiastic leaders.

Pre-existing Networks

Pre-existing networks generate new opportunities for coordination. These networks provide forums that might not otherwise exist to meet, identify, and respond to unmet needs. Forums at times are organized to respond to grants that are not subsequently funded. However, the existence of the forum itself provides an opportunity to identify and develop other collaborative efforts. For example, in Albany participating agencies convened to apply for an Office of Substance Abuse Prevention (OSAP) grant. While the grant was not subsequently funded, other programs emerged during the OSAP application process.

When governing boards of primary care providers include representatives of a broad cross-section of providers, these boards often are the source of new coordination opportunities. As participating agency representation increases, so does the number of collaborative opportunities that originates from these boards. Blue Ridge's board in Virginia is the most integrated of all of the CHCs we visited. Most participating agencies are represented either on the board itself or on one of the board's various subcommittees. This representation includes a seat for a health department representative mandated by Blue Ridge's by-laws. Many interviewees related that Blue Ridge's Board's multi-party representation was a major factor leading to the development of new efforts and the support of existing ones. Opinions varied among communities as to whether or not health department participation on CHC board represents a conflict of interest, particularly in communities where the health department is a funding source for the CHCs.

And finally, pre-existing funding contacts or the nose to find new resources are another important source of new potential collaborative opportunities. For example, because of his long-standing relationships with funders of special housing projects, the Executive Director of a housing authority in Albany related that he is routinely contacted when new funds are available and encouraged to submit applications. District Health Department directors in Texas and Virginia said that one of their roles was to alert the agencies to potential funding opportunities.

New Staff *with Different* ***Ideas/Expertise***

New opportunities are recognized in a number of the study communities when new staff members are recruited, often from other local healthcare organizations. Staff often have a history of circulating through jobs in other local related organizations. Their prior experience within these organizations promotes an understanding of those organizations' services, how they function, and what potential coordination opportunities exist. It was uncommon that an interviewee had not worked for more than one local health care provider.

At times, new perspectives and subsequent opportunities develop when staff are recruited from outside communities as well. For example, a nurse with migrant health experience in California relocated to Arrington, Virginia. Based on her experience in California, she identified an opportunity to develop collaborative services between Blue Ridge and the health department for migrant workers. It was a novel program for the Blue Ridge that staff related might not have developed otherwise.

3.2 Participating Agencies Are Able to Mobilize a Successful Response to the Opportunity

The existence of an opportunity for coordination alone is not enough to generate successful collaborative efforts. Participating agencies have to recognize the fact that the opportunity exists and mobilize a successful response to the opportunity. No one factor accounts for a successful response. Successful responses are characterized by a combination of factors that vary according to:

- **The size and complexity of the environment.** For example, in Arrington, a small rural community, participating agencies are small, often with few employees. It is easier to develop a shared understanding of what resources are available, who can provide them, and what additional resources are needed. These responses are often less formal and occur during routine day-to-day interactions. Chicago, in contrast, is much more complex. Responses are at times more process intensive and require more resources to generate an understanding of what was available and what is needed.

- **The complexity of the opportunity.** For example, generating new referral relationships often only requires developing a better understanding of the services other organizations provide. In contrast, more complex opportunities such as out-stationing Medicaid eligibility workers in CHCs requires additional funds, overcoming political constraints, and revised information system support.

The following factors are critical to successful responses to collaborative opportunities: idea champions/leaders, recognition that the whole is greater than the sum of its parts, ability to generate successful proposals, and communication/process. These factors are described in more detail below.

Idea Champions/Leaders

When they exist, large or small, opportunities have to be identified and acted upon. In the communities we studied, interviewees most often attributed the identification and response to an opportunity to a specific individual, or idea champion.

For the development of coordination efforts around discrete program opportunities, idea champions are often direct providers — case managers and social workers, for example. As direct providers, these employees often are in the best position to identify how collaboration can enhance existing services. In addition to being in a good position to identify needs, these employees are often most familiar with the types of services other agencies provide and the resources they have available to deliver those services.

Identifying coordination opportunities alone is not enough. To succeed, potential efforts require top-down commitment from leaders. In addition, these leaders promote successful responses to coordination opportunities because they are enthusiastic about ideas

generated among the staff and encourage risk taking and communication. For collaborative efforts designed to address broader delivery system issues, the leaders themselves are often the individuals who identify and lead efforts to respond to opportunities, such as how to develop coalitions of hospitals, health departments and community health centers to address ongoing primary care needs.

A Recognition *that* the *Whole is* Greater than the Sum *of the Parts*

Participants are characterized by multiple, and at times, conflicting perspectives. Successful responses are distinguished by an appreciation among participants that collaboration provides a whole greater than the sum of its parts. This requires looking beyond the interests of the individual agencies to the broader interests of the community. Coalitions of participants with a long history of working together are more likely to develop the mutual trust that promotes this perspective. For example, initially newer coalitions are more likely to succeed if they began by focusing on more neutral issues (e.g.., issues that do not threaten an agency's or organization's traditional operation systems). Working productively on less neutral issues more often requires a history of trust and prior successes. For example, Seattle hospitals and community health centers alike needed 24-hour access to translation services for a variety of Indonesian dialects and other languages (Russian, etc.). Organizations achieved much-needed economies by working together to hire, train, and oversee translators, Getting together over this neutral issue has promoted hospital/community health center collaboration over less neutral issues.

Ability *to Develop Successful Proposals*

While the ability to identify needs and develop coalitions to respond to them is important, successful responses also require developing strong proposals to potential funding sources that articulate how collaboration enhances primary care services and how resources would be combined to deliver those services.

Proposals must demonstrate that coordination efforts enhance primary care services. Potential grantors look to collaboration as a way to leverage limited resources and avoid unnecessary duplication. Therefore, interviewees related that successful proposals provide evidence that:

- Collaboration increases continuity and closes existing service gaps. For example, in Hidalgo County new AIDS programs provide needed case-management services that promote coordination across health and social service programs, inpatient and outpatient care.

- Proposed efforts build on existing networks of providers with proven track records. For example, the Whitney Young Health Center in Albany has pre-existing coalitions among participants that provide general primary care services, housing and services for substance abusers. These pre-existing coalitions facilitate grant applications to expand and build on those services.

- Efforts promote the development of new coordination efforts. For example, in Seattle access to inpatient obstetrical care for the indigent has been limited. Evidence that new collaborative efforts among hospitals and community health centers promote more coordinated inpatient and outpatient obstetrical care facilitated funding for an organized Community Obstetrics Referral Program (CORP).

- Efforts enhance access. For example, the health department and the CHCs in Miami developed a successfully funded immunization program because the health department provided vaccines and relies on the CHC's extensive decentralized networks to distribute vaccines.

In addition to documenting unmet needs, proposals must demonstrate that respondents have adequate resources to address needs. Resources included the requisite staff, space and finances. Often, new programs and services build on pre-existing resources; collaboration is viewed as a way to coordinate resources more effectively to increase service continuity and avoid duplication. For example, a major purpose of the Rural Health Outreach Program in Arrington, Virginia is to fund outreach workers who facilitate referrals across pre-existing networks of providers.

Generating strong proposals requires access to capable grant writers. These grant writers have a history of successes and are often from nearby educational institutions. At times, these experts are provided by the grantors themselves. For example, in Miami interviewees related that individuals from Bureau of Primary Health Care (BPHC) flew in to provide needed expertise in developing Miami's urban strategy report, a report required for Miami's NHSC application. The report was a blueprint for deploying NHSC physicians and enhancing primary care delivery among providers.

Communication/Process

The importance of adequate communication and process was repeatedly underscored as a factor in generating successful responses to opportunities. By promoting communication potential collaborators:

- Help ensure that all participants are vested in the proposed project. For example, at the Blue Ridge Medical Center, physicians related that their referrals to outreach caseworkers increased as they became more familiar with outreach services, Their interest in the success of the project also increased as they became more familiar with outreach services.

- Maximize opportunities to identify and draw on the respective strengths of various participants. This is particularly important in the larger communities where understanding what each participant has to offer is more difficult. For instance, in Seattle, extensive communication across providers for the homeless program has resulted in a program that efficiently draws on the resource of all its providers.

- Minimize misunderstandings that risk developing mistrust. For example, collaborative efforts in Chicago have long been impeded by lack of communication and mistrust that has subsequently developed. New multi-party forums have begun to break down this mistrust.

3.3 Once Collaborative Efforts Are Successfully Initiated, Participating Agencies/Organizations Were Able to Sustain Them.

Like the ability to respond to opportunities, the ability to sustain collaborative efforts once they are developed depends on several factors that include: efficient operations, ongoing financial viability, capable staff, ongoing communication and process, and information support systems.

Efficient **Operations**

Particularly important to sustaining coordination efforts are efficient and user-friendly operations. However desirable the collaborative efforts appear on paper, those that are cumbersome and difficult to use ultimately discourage potential patients and referrals. Efficient operations require strong administrators and capable staff who continually look to ways to improve operations and deliver services in a timely and efficient manner. Common efforts to increase efficiency include:

- Identifying ways to reduce waiting times and the rate of no-shows.
- Monitoring patient satisfaction to identify opportunities to improve services.
- Encouraging frontline employees (including physicians) to be involved in identifying ways to increase efficiency.
- Freeing physicians from non-clinical tasks to the extent possible to increase their clinical availability.
- Educating patients about how to use existing referral systems.
- Providing ongoing staff training on, for example, how to facilitate referrals and fill out forms.

More recently, participating agencies have looked to co-location as a way to promote efficiency. More common examples of co-location are the outstationing of Medicaid eligibility workers in CHCs. In Seattle plans are underway to co-locate a health department pediatric clinic and CHC in a new facility. Co-location of these two organizations is viewed as a way to maximize potential synergies, but participants reported that major operational hurdles need to be overcome, including dealing with non-integrated medical record systems and independent appointment systems.

Ongoing Financial Viability

Coordination efforts are successful not only because they are efficient; they remain financially viable as well because:

- Collaborative efforts leverage the staff and financial resources of existing programs, helping to keep them viable. For example, Hidalgo County's Breast and Cervical Cancer Clinic relies on cross-referrals, cross-staffing, and shared equipment among the Pharr Clinic, the Hidalgo County Health Department, and Planned Parenthood. If Planned Parenthood lost major funding, the clinic's ongoing operation could be jeopardized.

- Collaborative efforts are supported by a critical mass of patients. Sufficient demand exists and interagency referral networks help meet that demand.

- Programs either became self-sustaining over time or generate new funding when existing funding is no longer available.

Capable Staff

While strong leaders are important to initiate programs, capable staff (both clinical and non-clinical) are essential to maintain them. As liaisons among agencies, staff members are important in facilitating referrals, which require strong interpersonal skills and credible training and expertise. Like strong leaders, strong staff members also seek to serve the broader needs of their patients over the more narrow interests of their own organizations, encourage communication across agencies, and in general are quite enthusiastic about their jobs.

Training and expertise are often acquired in prior related jobs. It is more common than not to find that interviewees previously worked in related organizations. Staff are vested in participation efforts because they are often from the community and view their efforts as highly important to improving their community's welfare.

The strength of existing staff members is particularly important in recruiting new staff. Many newer employees related that the reputation of existing staff members was important in their decision to join a particular organization attracting them to their current positions, particularly for difficult-to-fill spots. For example, where a shortage of pediatric subspecialists existed, Hidalgo County was able to attract new subspecialists because existing subspecialists were active in recruiting and conveying an awareness and enthusiasm for potential services.

All organizations related that the NHSC earlier had substantially enhanced the qualifications of the clinical staff, facilitating affiliations with educational institutions and hospital credentialing in addition to providing much needed medical leadership. Often NHSC physicians become established members of their communities and active participants in community projects such as health school fairs and wellness events. Affiliations with educational institutions are attractive to potential recruits who look to those institutions for

teaching opportunities and faculty appointments. These affiliations are common where AHECs are established but exist elsewhere as well.

Ongoing Communication/Process

An important factor sustaining collaborative efforts is on-going formal and informal communication. Communication is important to keep participants informed of relevant issues, for example, what referral networks exist and how to use them. Communication is also important to minimize misinformation, false assumptions and destructive rumors, the potential for which can not be understated. Communication, while often process- and resource-intensive, is also viewed as important in vesting individuals in programs by ensuring that their perspectives are understood and shared. And finally, interviewees related that successful efforts require involving as many levels of staff as possible in implementing and maintaining agreements. For example, in hiring new workers for the Seattle's homeless grant, the lead agency gives participating agencies opportunity to interview potential new staff members.

Larger, more complex, collaborative endeavors are characterized by more formal networks for communication. Participants meet regularly and represent all key agencies. Smaller, more discrete, programs are often characterized by more informal communication linkages among providers.

Information Support Systems

Prior to starting the study, we anticipated that ongoing coordination efforts would have access to information that enabled participants to track users and closely monitor outcomes (in addition to helping participants identify needs in designing collaborative programs). We found that information systems are not highly developed and that, in most cases, more sophisticated monitoring and tracking are not done. User rates are the most commonly measured and readily available indicators of program success. These limitations are particularly common where coordination efforts are organized around discrete programs. Where primary care providers are organized to address broader system-wide issues, a higher priority is placed on and more resources are available for developing more sophisticated outcomes measures. For example, in Chicago efforts of the new consortia organized to reform primary care systems commonly include outcomes measures to evaluate the success of their efforts.

Miami is the only one of the six sites where participating agencies, including the hospital, the CHCs and the health department, share computer linkages across their primary care clinics. These innovative computer linkages provide unique opportunities for cross-scheduling, obtaining lab results and tracking where and whether patients seek care from other providers in the system.

Although a major assumption driving coordination efforts is that they save funds by eliminating redundant services, no formal studies or information systems exist to quantify these savings. Similarly, quality improvements resulting from coordination efforts are anecdotal and not measured with formal outcomes standards.

3.4 Generalizability of Lessons Learned

Despite the uniqueness of each study community, our findings suggest that a number of generalizable factors contribute to the successful development of coordinated primary opportunities, Overall, opportunities for collaboration or threats to business as usual must exist, be acted upon, and once initiated be sustained. Contributing factors that are highly generalizable across communities include the following:

- **Strong leaders** who instill a top-down commitment to collaboration, innovation from the bottom-up, a spirit of mutual trust and collaboration, and who have a vision for achieving broader delivery system reform that transcends the needs of their individual organizations.
- **Ongoing forums** for primary care providers to meet and identify local needs and the resources to meet those needs; forums that institutionalize collaboration.
- **Unmet needs and the financial and staffing resources externally** and internally to meet those needs.
- **Extensive communications and process among** all staff within and external to the organization to minimize the not insignificant potential for miscommunication and mistrust that can undermine collaborative efforts.
- **The ability to view coordination as a whole greater than the sum of its parts.**
- **Efficient operations** that encourage referrals and ongoing use of the services being coordinated.
- **Ongoing financial viability** for a variety of reasons that might include: coordinated services leverage the staff and resources of existing programs, a critical mass of patients exists, and programs become self-funding or generate new funding when existing funding no longer exists.

While the factors that characterize successful collaborative efforts are highly generalizable, how participants organize to address collaborative opportunities may differ among communities. For example, smaller communities with fewer providers may achieve effective collaboration through more informal organizations; larger communities may require more formal relationships, particularly to the extent that the community is attempting to overcome long-standing barriers to coordination,

CHAPTER IV: IMPLICATIONS FOR HRSA

HRSA can do much to encourage the growth of more primary care coordination efforts in the communities that it serves. Although the Agency must respect each community's distinct demographic, delivery system, and political dynamics, it can provide incentives and resources that enable collaborative leaders to function. We have organized the implications of our findings into the following areas:

- Flexible funding oriented toward the development of primary care systems.
- Targeted focus on CHC health department collaboration.
- Longer-term professional assistance.
- Impact-focused evaluations.

Flexible Funding Oriented toward Development *of Primary Care Systems*

The coordination efforts in this study have evolved in response to external opportunities (e.g., HRSA funding requirements) or serious threats to the local delivery systems (e.g., inadequate overall primary care capacity). HRSA has often played a major role in promoting these joint and multi-party efforts, The study suggests that this role has been successful because HRSA funding has promoted the development of local relationships that define themselves over time, in a way that builds on unique local professional and agency relationships and political and funding constraints.

- Recommendation: HRSA funds should continue to be used to support primary-care focused collaboration rather than categorical coordination programs (e.g., primary care-substance abuse linkage projects). Over. the next decade, HRSA should encourage communities to build primary care infrastructures rather than parsing funds on a categorical population or disease basis, which tends to fragment care. Communities are in the best position to define how to configure their primary care systems to meet various and changing health care needs,
- Recommendation: Federal dollars can provide an incentive to coordinate, but should neither dictate the shape of the table nor the seating arrangements. While it may be tempting to try to export or replicate models, insufficient information exists to be confident in suggesting how to configure effective collaborative arrangements.
- Recommendation: HRSA should expand its dialogue with foundations to identify local agencies that would be interested in supporting community-based primary care coordination projects. Seattle and Chicago are two examples

where local foundations have played a critical role in both initiating and providing ongoing support so essential for staffing the collaborative efforts.

- Recommendation: HRSA should further strengthen the linkages between its health professions training programs and primary care providers. As we have seen, AHECs and residency programs have been key participants in a number of communities,

Targeted Focus on Collaboration between ***CHCs*** and **Health Departments**

The degree of collaboration between health departments and other primary health providers varies considerably across communities, The extent to which health departments coordinate primary care services and provide primary care services themselves also varies from state to state and within states. Seattle and Chicago, for example, clearly demonstrate that some health departments are interested in leveraging the resources and capacity of community health centers. However, in other communities, health departments are viewed as bureaucratic, at times inefficient, and less innovative. Coordination efforts in those communities were often developed by other lead agencies as ways to address health department constraints.

System integration takes both vision and time. It also takes considerable good will and leadership to sort out the complex legacy of historical boundaries between health department responsibilities and those of other organized primary care providers.

- Recommendation: HRSA should provide seed money to health departments and community health centers that demonstrate an interest in and action plans for developing or enhancing pre-existing relationships. Efforts such as Seattle and Chicago should be both supported and given greater visibility. HRSA should work internally to identify its current funding streams (e.g., BHRD, Bureau of Primary Health Care [BPHC], MCHB) that can be leveraged to support primary-care-oriented collaboration.

- Recommendation: Categorical funding streams are part of the problem -- potential barriers to a broader vision of integrated primary care systems. HRSA should examine all its programs to identify inefficiencies and conflicting requirements that may introduce barriers to coordination efforts. These may include issues such as overly restrictive categorical requirements that are potential barriers to a broader vision of integrated primary care systems, inconsistent proposal and reporting requirements, and even differing grant years. Some changes could be made in HRSA's professional program management. Others require legislative authority.

Longer-Term Assistance

As the scope of primary care expands to encompass various health-related problems, such as substance abuse prevention and treatment, HIV-AIDS, and multi-problem populations

(e.g., homeless), communities are more likely to work together to leverage their respective expertise and resources to amass the critical mix of services. The case studies illustrate how HRSA has provided much-needed expertise to support coordination efforts, such as HRSA's technical support for the development of Miami's urban strategy plan.

- Recommendation: HRSA should fund forums for sharing communities' expertise and experiences. While Federal dollars are often used to initiate coordination rather than expand the focus of ongoing collaborative ventures or establish mechanisms for nurturing fledgling efforts, more attention could be paid to the latter.

- Recommendation: HRSA should designate small but targeted professional-assistance funds to aid communities embarking or enhancing coordination efforts. Such funds might help pay for planning efforts, proposal writing, development of information systems, or other needs that the communities themselves identify.

Impact-Focused Evaluations

Insufficient attention has been given to documenting the goals and program objectives against which coordination activities can be assessed. Although case studies can highlight factors contributing to ongoing collaborative activities, more rigorous evaluations should be based on quantifiable measures of impact and/or success.

Since no agreed-upon measures now exist for analyzing the effects and/or comparing the value-added benefits of different coordinated primary care activities, it is timely to develop such measures before funding additional research.

- **Recommendation:** HRSA should convene key players from several coordinated primary care programs to develop consensus measures for future evaluations. It is important to involve the participants in developing measures that correspond with their own goals and objectives. Too often evaluations set broad criteria that do not reflect the projects' own objectives — and thus are unable to assess relative success,

- Recommendation: Future evaluations should be multi-year, providing both interim assessments as well as feed-back to the study sites. Collaboration and systems building is not a short-term, flashy initiative. The research design should have a longer time horizon, if HRSA is to learn from the experiences of the study sites. All too often the evaluation time horizon is too short for learning what it takes to change a local delivery system. The present six case studies indicate that it takes years, not months, to make a difference.

- **Recommendation:** HRSA should seek local foundation co-sponsorship of evaluations, particularly in communities supported by foundations in developing their coordination efforts.

In summary, over the last several years communities have increasingly looked to coordination as a way to leverage limited resources and provide more integrated and continuous patient care. This requires considering the needs of the whole patient (for example, not just medical needs but concomitant social needs as well) and integrating the often fragmented services of multiple providers. In the case studies, HRSA was an important participant in many of these efforts, first by serving as a catalyst that initiated efforts and then by allowing providers to define their own systems of coordination according to their unique needs and operating constraints. HRSA can continue to play that very important role. While quantifiable measures in support of coordination do not readily exist, the testimonials of multiple providers in the case study communities do.

APPENDIX A: INTERVIEW GUIDES

HRSA PRIMARY CARE COORDINATION PROJECT -
ON-SITE INTERVIEW GUIDE

INTERVIEWEE NAME
AFFILIATION:_____

Begin with general questions about how long the interviewee has been with the agency and in what capacity. Be sure to ask the following at some point during the interview:

- What three factors were most important to the success of this project?
- What factors would have led to the project's failure?

1. PROFILE: COMMUNITY-SERVICE AREA

As an introduction to **[NAME], we** are interested in profiling both community and population characteristics, particularly those that have played a role in the formation of [NAME].

1. **Please describe the community's population *characteristics,* particularly socio-demographic and health status characteristics that were important considerations in the formation of the [NAME].**

   Probes:

   1A. Over the past decade, have there been significant changes in demographics, extent of poverty, unemployment, and/or housing problem?

   1B. What are the major social problems within your community? Employment related problems? Education? Availability of social welfare services? Homelessness? Substance Abuse? Teen pregnancy? If others (specify):

   Do you have any recent reports that document the extent of these problems?

   IF YES, OBTAIN COPY OF REPORT.

   1C. What are the major *health status problems* within your community?

   Have there been any recent studies or surveys that profile major health status problems? Do you have supporting statistics to document the extent of these health problems? If yes, please discuss.

   OBTAIN COPY OF ANY AVAILABLE ***STUDIES/REPORTS.***

2. **Within your community, what population group(s) are most in need of *publicly* supported *health* and *related social services?***

Probes:

2A. Have you recently conducted any surveys or studies to identify populations most in need of additional services and/or outreach efforts? If yes, what were the findings?

OBTAIN REPORT OR DOCUMENTS.

2B. Over the past decade, have there been any significant changes in the number and types of individuals requiring additional health care and related social services?

If yes: To what do you attribute these changes?

If no: Does this suggest success or failure in the community's efforts?

2C. Are there any persistent service gaps? Please specify and discuss reasons for community's inability to meet target population's needs.

Consider separately primary care and other types of health ***and/or*** *social services.*

3. There has been substantial growth in the heath care sector over the past decade. We are particularly interested in the community's health care delivery system and reviewing changes over the past several years.

Please describe the current *health* care delivery system and any significant changes over the past several years. More specifically, we are interested In major primary care providers and specialty providers, particularly those that offer services to attempt to address the community's various health problems (eg., perinatal care, addiction).

Probes:

3A. To what extent is access to primary care a problem for community's population?

3B. What statistics, if any, do you have to document the extent of the access to care probiem?

3C. What statistics, if any, do you have to document these problems for other types of health care services, particularly those that address community's major health status problems?

OBTAIN *ANY AVAILABLE REPORTS OR DOCUMENTATION.*

3D. Over the past several years, have there been any significant changes in the number or type of primary care providers serving the target populations?

If yes: To what do you attribute these changes?

If no: What efforts have been made to improve access to primary care and/or increase the capacity of the primary care delivery system?

3E. To what extent has there been an increase (or decrease) in the number and/or type of specially providers in areas of specific community needs (eg., health promotion, substance abuse prevention/treatment, child health)?

3F. What are the community's service delivery system priorities? For example: Increasing number of private sector providers serving the poor? Improving the capacity of C/MHCs? Increasing health department and/or public agency service delivery capacity?

3G. Are C/MHCs and/or health department clinic providers viewed as "providers of last resort"?

IF YES: By whom? What are the implications for future improvements in access to basic and primary care services?

IF NO: How would you describe their role(s) within t e community's primary care delivery system?

4. At **this stage, what do you consider to be the most compelling primary care** *delivery system problem(s)?*

Attempt to classify 'problem' in terms **of (1)** redressing individual and/or cultural barriers to care; (2) improving coordination among available primary and specialty services to facilitate access to full range of necessary services; (3) increasing primary care capacity - number and/or type of providers willing to serve the target populations. Note other response(s) and classify appropriately.

Probe:

4A. What are second and third most pressing primary care delivery system problems?

4B. Do you think that these problems are generally regarded as priorities within the community? Why?

II. PARTICIPATING AGENCIES: OVERVIEW

Before we go into detail about the primary care coordination project, it would be useful to develop a broader understanding about of the organizations that participate in the project, how long they have existed, the types of services they deliver in general, etc.

1. How long has [Name of participating agency] existed and how is it organized? What are its primary objectives? How do these objectives relate to the objectives of the primary care coordination project?

2. What general types of services does [Name] provide?

3. What are its target populations?

4. How have its services, utilization, organization, etc. evolved over time

5. How is it funded?

6. What is your historical relationship with this agency? In addition to the primary care coordination effort, have you undertaken other projects with this agency?

III. COORDINATION EFFORTS: KEY FEATURES AND PRIORITIES

We are especially interested in understanding "coordination" activities within your community, particularly their origin, formal structure and roles of major players.

1. **Please tell us about the history of [NAME]. How did it evolve? What was the major impetus for its establishment? Did they evolve as a result of specific threats? Opportunities? Any organizational/regulatory/funding barriers that were impediments to getting the project off the ground? If so, how were they overcome?**

   Attempt to determine origin of formalized coordination: (1) federal grant requirements; (2) foundation grant funding requirements (e.g., RWJ); (3) voluntary local initiative to address a specific problem; (4) evolved from a series of local collaborative activities among various health care organizations; (5) response to state grant requirements or funding incentives; (6) efforts of one or more committed leaders of the community.

   Probe: Was there informal collaboration before the formal coordination was established?

2. **What is the formal or legal structure of [NAME]?**

   Probes:

   1 A. Legally incorporated entity? Formal Consortium? Loose confederation?

   1 B. First year of formal operations as **a legal or quasi-legal** entity?

   1 c. Have there been any changes in the formal structure over the past several years?

   IF YES: Why?

3. **Do you have a mission statement? Specified goals? If specific goals have been established what are they? Are they in writing?**

   IF YES, DISCUSS AND OBTAIN DOCUMENT (S).

   IF NO: How would you describe its mission and goals? Probes:

   3A. Have the goals changed over the past several years?

IF YES: How and why?

3B. Direct inquiry to **assess** extent to which the "mission and goals" relate to the previously stated priority problems (see Question **1.4: At this stage, what do you consider to be the most compelling** *primary* **care** *delivery* **system *problem(s)?).***

4. Who are the members of [NAME]?

Probes:

4A. Do they represent all of the major health care organizations and providers in the community?

4B. Are the current members the same as those involved in the creation of (NAME]?

4c. Are there any important health care agencies, providers or organizations which are not involved in **[NAME]**

IF YES: Why aren't they involved?
Should they be encouraged to join [NAME]?
Are there any current efforts to involve them?

5. Have any individuals or organizations played a particularly important leadership role?

Probes: Focus on leadership re: (1) forging the coalition; (2) keeping it together; (3) facilitating coordination activities; (4) providing resources and/or funding at critical stages in its evolution; (5) resolving potential conflicts among members?

5A. Has there been one individual or organization that has been a critical force or has taken an important leadership role?

5B. Has there been one individual that might be considered the guiding force?

5C. Has there been any individual who has served as the mediator in promoting consensus and joint activities?

6. **How would you describe your (1) personal and (2) organizational role in [NAME]?**

Probes:

6A. How long have you personally been involved with [NAME]?

6B. Has your personal or organizational role changed over the years?

IF YES: How.? Does this reflect changes in your organization's commitment to (NAME]?

7. Since its origin, has [NAME] undergone major changes that would impact on its ability to promote its goals?

IF YES: What changes? Implications for achieving goals?
Probes:

7A. Leadership?

7B. Funding?

7c. Staffing?

7D. Other organizational attributes that would influence operations?

7E. Assessment of community's health care problems and/or resources?

7F. State and/or Federal health policies?

IV. STRUCTURAL AND OPERATIONAL FEATURES

Please describe the formal organizational structure.

OBTAIN ORGANIZATION CHART, IF AVAILABLE.

Probes:

1A. Is there a policy-making entity (eg., Board of Directors, Steering Committee)?

1B. Are there standing committees and/or subcommittees

1C. Are task forces established to deal with specific issues?

1D. Is there a formal process for determining who will serve on the various committees and/or task forces?

2. **Does [NAME] have an annual budget for its administrative operations?**

Probes:

2A. What is the current year's budget?

2B. What are the revenue sources?

2c. Who is involved in decisions on allocation of the administrative budget?

3. **Is there a paid staff?**

IF YES: Who is involved in recruitment?

IF NO: Do member organizations contribute staffing assistance?

Probes:

3A. How many FTES? Paid staff? Volunteers? In-kind services?

3B. What are staff roles and responsibilities?

4. **Community-based collaborative activities vary significantly in terms of formal meetings, formal decision-making rules and joint ventures?**

4A. **With** respect to meetings:

Do you maintain a regular calendar of scheduled meetings?
How often do you meet?

Do you maintain minutes?

Are your meetings open to the public?

4B. With respect to formal decision-making rules:

Are all members "vote' on major policy decisions?

Are decisions arrived at through consensus (eg., discussion and negotiation rather than formal votes).

4C. With respect to joint ventures and/or consortia sponsored activities:

Generally involve agreement among the interested parties?

Require agreement among all **members of the consortia?**

5. **We would like to develop a more detailed profile of governance activities within your organization, and request your assistance In filling out Exhibit A-C, as applicable to [NAME].**

Exhibit A: **OFFICERS**

OFFICERS	ORGANIZATIONAL AFFILIATION	OFFICIAL RESPONSIBILITIES
Chair or President		
Vice Chair or Equivalent		
Secretary		
Treasurer		
Other [SPECIFY]		

Exhibit B: STANDING COMMITTEES

COMMITTEE	CHAIR/ORG. AFFILIATION	NUMBER OF MEMBERS	NUMBER OF MEETINGS/YEAR

Exhibit C: MEMBERSHIP

MEMBER/PARTICIPANT ORGANIZATIONS	**PRIMARY ROLE(S): PROGRAM POLICY PARTICIPATING PROVIDER; ADVOCACY; COORD. FACILITATOR; PROJECT FUNDING; PROJECT OVERSIGHT**

[NOTE: These might be completed in advance]

V. COORDINATION PROJECTS/COORDINATED DELIVERY SYSTEM

1. Please describe current 'consortia' projects.

For each project, obtain the following information:

1A. Description of project goal, volume of services (where applicable), expenditures/costs if available.

1B. Participating providers, by name, type of organization, scope of services being provided, and some measure of the volume of services provided to target population(s).

1C. Other member contributions, by organization and type of contribution (eg., funding, staffing, technical assistance, outreach).

1D. Rationale for project design, including documentation of community or special population needs and/or evaluation of service delivery system problems and/or gaps.

1E. Organization's assessment of how effective the project is.

2. **Are current projects being evaluated to assess their impact?**

Probes, by project:

2A. What information currently exists to measure impact? internally? Externally? Who generates and receives the information? How often? Is the information used to formally assess the project's success?

2B. Did the information systems exist prior to the implementation of the project or were investments made to upgrade systems as a result of the project?

2B. Is consortia funding formal evaluations?

2c. Is there Federal, state or foundation funding for evaluation(s)?

2D. Have any studies been completed?

IF YES: What were the findings?

3. How do each of these projects (or activities) relate to the [NAME] missions and/or stated goals?

Probes, by project:

3A. What organization(s) and/or individual(s) are likely to play a lead role in assuring the project success?

3B. What would you consider success indicators?

4. **What other joint ventures and/or collaborative activities should be developed?**

Probes:

4A. Are they now in a planning stage?

4B. **What role do you envision for** your organization?

4c. Are there any Federal or state barriers to implement on? Regulatory? Lack of adequate resources/funding?

VI. **SELF-ASSESSMENT**

1. **Based on your experience and efforts thus far, how would you describe [NAME] strengths in attaining its goals?**

Probes:

1A. Bringing various parties together to **address** community problems.

1B. Increasing the scope of services available within the community.

1C. improving provider relations and inter-agency coordination, including both primary **care** and specialty agencies.

ID. Raising awareness of serious community access to care problems.

1E. Improving primary care delivery system capacity.

1F. increasing access through organized primary care providers (eg., C/MHCs).

1G. Improving health department's ability to provide a broader range of primary care services.

1H. Establishing a forum for future collaborative efforts to improve both access and range **of services for special and underserved populations.**

2. **Thus far, what have been your most significant accomplishments?**

3. **if pressed, how would you describe your weaknesses or short-comings in furthering [NAME] goals?**

Probes (see #1).

4. **What would you suggest doing differently in order to address these weaknesses?**

5. **What assistance, if any, might the Federal government offer to facilitate collaborative activities within your community?**

Probes:

5A. **Reconciling various and disparate regulatory requirements?** Specify and explain resultant implementation problems.

5B. Reducing overlapping regulatory and reporting requirements? Specify, providing concrete examples.

5C. Providing funds for primary care coordination innovation in ways that achieve requisite accountability but do not require specific program structures that may not **apply** to a particular community situation, **Seek examples.**

5D. Undercutting performance when Federal funds are reduced whenever program **meets or exceeds** its goals. Seek **examples.**

5E. Providing technical assistance and forums for exchange **of** 'best practice' **lessons.**

VII. **LESSONS LEARNED FOR BEST PRACTICES GUIDANCE**

1. **If you had the opportunity to start anew** in **structuring [NAME], what would you do differently?**

Probes:

1A. Why?

1B. How might this change affect your organization?

1C. What impact would this change have on collaborative activities within your community?

2. Is **(NAME] planning to make any changes in the way it operates or makes policy decisions?**

Probes:

2A. Changes in the way in which it promotes collaboration among community providers and agencies?

2B. Changes in the way in which it assesses community health care needs and/or access to care problems?

3. **What lessons have you learned about achieving better coordination among various health care providers - community health center, public health agencies, social services organizations, private practitioners and/or institutional providers?**

Probes:

3A. **C/MHCs** and health departments.

3B. Health and social service agencies.

3C. Regulatory and funding agencies.

3D. Public and private sector providers.

3E. Primary **care** providers and key specially providers.

3F. Organized primary **care** providers and medical schools,

4. **Leadership generally plays a critical role in effective organizations or achieving stated goals. What leadership lessons can you share?**

Probe:

4A. Is it necessary for someone or some organization to **take** to **lead?**

4B. To what extent **has one** individual **or** organization **served as** the critical motivator in forging the coalition?

4c. What are the characteristics of leadership that are likely to make the most difference in building a consensus and/or sustaining collaborative efforts?

5. Based on your experience, what advice would you give to another community, organization or individual who is trying to start a coordinated effort like yours?

Probe:

5A. Do you think your experiences are transferrable to other communities?

5B. Were there unique features of your community which particularly fostered effective coordination? (examples: strong sense of community identity; lengthy prior experience with informal relationships; small community where everyone knows everyone else.)

APPENDIX B: ARRINGTON, VIRGINIA

HRSA PRIMARY CARE COORDINATION
C A S E STUDY SITE REPORT

BLUE RIDGE MEDICAL CENTER
ARRINGTON, VIRGINIA

TABLE OF CONTENTS

CHAPTER I: INTRODUCTION

This report details the findings from the site visit to the Blue Ridge Medical Center (BRMC) in Arrington, Virginia, for HRSA's study on lessons learned/best practices for coordinating primary care. Chapter I provides an overview of Nelson County, BRMC's target market. The history of BRMC, its services and the services of other agencies that participate in the primary care coordination efforts is presented in Chapter II. The coordination efforts are discussed in Chapter III, and the lessons learned and best practices elucidated during this site visit in Chapter IV.

BRMC is located in Nelson County, Virginia, a rural county situated in central Virginia with the Blue Ridge Mountains on its western border and the James River on its eastern border, The county has 12,200 residents in a 471 -square-mile region that is characterized by the absence of stoplights and major industries. The diamond-shaped county is divided into four magistrates (clockwise from north): the Rockfish Valley, Schuyler, Lovingston, and Massies Mill. The Blue Ridge Medical Center is situated in Lovingston (see Exhibit 1).

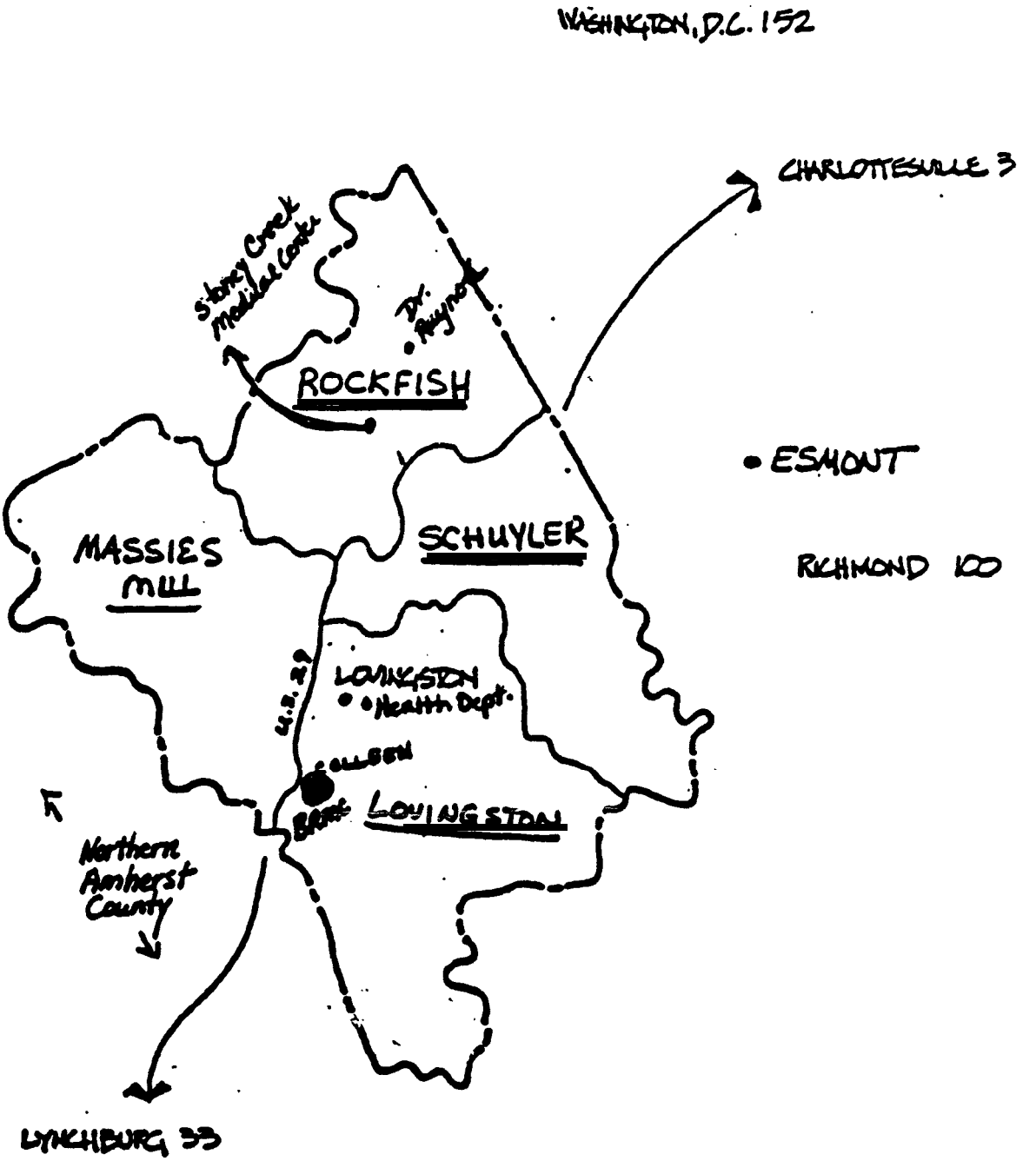
Demographics of Community and Center Users

The county's rural population contains a high percentage of elderly and impoverished residents and includes a small percentage of migrant farm workers. Sixteen percent of Nelson county residents are elderly, Many residents lack transportation and are geographically isolated from health care and social services, BRMC reports that 51 percent of county residents live below 200 percent of the poverty level; the median income in 1988 was $22,500. Migrant or immigrant farm workers constitute approximately 1 percent of the county residents. A 1989 survey by the Nelson County Community Development Foundation reports an illiteracy rate of 44 percent, as measured by the number of people who failed to complete the eighth grade.

During fiscal year 1990-91 the Center reports that 74 percent of its users are white, 25 percent African-American, and one percent Hispanic, mainly Mexican-American. The user group is fairly reflective of the county's racial composition, although a larger fraction of the user population (25 percent) is African-American than the county (18 percent).

Because the center is one of the few primary care providers in the area, it also serves a large number of insured patients. Some 42 percent of its users are privately insured. Of the remainder, approximately 21 percent are uninsured, I6 percent are on Medicaid, and 21 percent are covered by Medicare.

Exhibit 1
Nelson County, Virginia



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Local Economy

As there are no major industries in the area, Nelson County serves as a bedroom community for residents who commute north to Charlottesville and south to Lynchburg. The largest employers in Nelson county are the Wintergreen ski resort and the public school system; the remainder of the local economy is characterized by small businesses, many of which have recently experienced staff reductions due to the recession. There is little agricultural production in the area, although a number of apple and peach orchards are operated by county farmers.

Related *Health* and Social Service Issues

A review of BRMC's general user characteristics and discussions with interviewees indicate that patients present a host of primary care problems, often with avoidable complications because of delays in seeking treatment due to a combination of illiteracy, geographical barriers and poverty. In addition, needs assessments point to stress, poor nutrition, and lack of exercise as additional factors of concern. Substance abuse is problematic as well, particularly among the county's elderly residents, but abuse is generally related to alcohol and prescribed drugs, rather than illicit drug abuse. While migrant farm workers do not represent a large fraction of the population, they also present unique health concerns, including a higher incidence of tuberculosis.

Primary *Health* Care Delivery System

The Blue Ridge Medical Center is the primary source of medical and health care for the entire county. One private physician practices in the Rockfish Valley satellite practice established by University of Virginia at Stoney Creek Medical Center, located at the other end of the county. This center, the only other "clinic" practice in the county began as an orthopedic practice to serve Wintergreen ski resort. The clinic has been under several organizational auspices. Operated for a while by Lynchburg Hospital, it then closed and was reopened by the University of Virginia. Primary care is also provided, as discussed later in this report, by the county health department, located in the town of Lovingston a few miles from BRMC.

There are no hospitals in Nelson County, and the nearest facilities are 35 miles away. Northwest of the county, Charlottesville's Virginia Baptist Hospital and the University of Virginia Medical Center serve the northern end of the county, while Lynchburg General Hospital serves many of the county's southern residents.

Prior to BRMC's starting operations in 1985, many of the county's indigent residents travelled to the oftentimes distant hospitals (particularly University of Virginia) to obtain primary care; or they did not seek care at all. New primary care services at BRMC that supplemented limited existing health department services resulted in major increases in access to primary care services locally.

Summary

In summary BRMC's community includes problems endemic to rural areas including a high proportion of homebound elderly residents, geographic isolation, lack of transportation, illiteracy, and diseases that are often preventable when access is optimal. The table below summarizes and compares selected factors for the BRMC service area and its users is included below.

SERVICE AREA AND USER CHARACTERISTICS OF THE BLUE RIDGE MEDICAL CENTER'

	SERVICE AREA [PERCENT]	USERS [PERCENT]
Race/Ethnicity		
White [Non-Hispanic]	82.0	74.0
Black/African-American [Non-Hispanic]	17.0	25.0
Hispanic/Latino [of any race]	1.0	1.0
Other	0.0	0.0
Income		
Over 200% of Poverty	49.0	Unavailable
151-200% of Poverty	15.0	Unavailable
101-150% of Poverty	18.0	Unavailable
At or Below Poverty	18.0	Unavailable
Insurance Status		
Medicaid	7.0	16.0
Medicare	16.0	21.0
Other	66.0	42.0
None	11.0	21.0

[1] This chart has been adapted from the 1992 Blue Ridge Medical Center Section 330 Continuing Funding Application

CHAPTER II: DESCRIPTION OF LEAD AND 'OTHER AGENCIES/ORGANIZATIONS THAT'PARTICIPATE IN PRIMARY CARE COORDINATION EFFORTS

2.1 Blue Ridge Medical Center

In one respect, Blue Ridge is unique among the centers we visited: low population density and lack of medical resources within the county have made the center the major provider of care to all strata of the population. Forty-four percent of BRMC's patients are privately insured, This broad base of support places BRMC in the center of the county's primary care system, fostering its role as a leader in pulling agencies together to obtain more resources,

In addition to providing comprehensive primary health care services, the Center offers specialty medical care, and community and social services. The Center operates as both a medical facility for citizens of Nelson county and a community resource for health care information, referrals, and services.

Founded in 1983 by a local citizens group, the medical center opened its doors in 1985, using funds from a Public Health Service grant. At the time, the Center was staffed by only one physician and one nurse. Over the next four years, BRMC added a nurse practitioner and a second physician, while doubling the size of its facilities. The current staff of the health center is 12, including providers, administration, and support staff. In fiscal year 1991, the Center handled over 12,500 visits from more than 4,000 individuals.

The Blue Ridge Medical Center provides the following services to its community:

- Family Practice
- Obstetrics & Gynecology
- Orthopedics
- Podiatry
- X-Ray
- Acupuncture
- Nutrition Counseling
- Physical Therapy
- Nursing Care

Family practice, X-Ray, and acupuncture services are available Monday through Friday, while other services are provided during one morning or afternoon each week. A case management approach is being applied in the tracking of prenatal patients.

As indicated in the table below, 1992 patient and grant revenues are estimated at approximately $750,000. Patient revenue accounts for 65 percent of this figure. Slightly more than one-third of patients are self-paying, although Medicare and private insurance also contribute more than $200,000 to BRMC revenue.' Section 330 Rural Health Outreach Grants provide $174,691 and $88,457, respectively. Without federal assistance, BRMC clearly could

not provide services. Blue Ridge has been experiencing some difficulties with its reimbursement. Internal problems at the third party payers have led to delays in receiving payment; excessive administrative time is required for the BRMC financial manager to process, correct, and wait for cost settlement.

1992 ESTIMATED REVENUE - BRMC			PERCENT OF TOTAL
Patient Revenue			
MEDICARE	$ 144,082		
MEDICAID	59,726		
PRIVATE INSURANCE	103,086		
SELF-PAYING	179,107		
Total Patient Revenue		**$ 486,001**	**64.9**
Section 330 Grant		**174,691**	**23.3**
Rural Health Outreach Grant		88,457	11.8
Total Revenue - 1991		749,149	

BRMC's small staff (12 people) mitigates the need for an extensive organizational structure. The Center is managed by an administrator and medical director. The administrator oversees the operation of the Medical Center, while the medical director supervises the clinical staff. The head nurse directs nursing and patient flow. A financial manager is responsible for the Center's computer operations, payroll, and accounts payable and receivable.

The Center is a member of a six-agency consortium united under the Rural Health Outreach Grant to increase access to and utilization of the health services in the Nelson County area. The consortium includes BRMC, Monticello Community Action Agency (MACAA), the Jefferson Area Board for the Aging (JABA), Region Ten Community Services, the Nelson County Health Department, and the Nelson County Department of Social Services.

2.2 Description of Other Participating Agencies/Organizations

A host of organizations and agencies participate in primary care coordination efforts with BRMC. The primary participants are listed below:

Nelson County Department of Health

The Nelson County Department of Health (NCDOH) is a branch of the Thomas Jefferson Health District. The health department has been actively involved with the Center since the Center's inception. BRMC's bylaws have a provision that includes a standing board

position for a Health Department appointee, The current appointee was involved in developing the Center's original grant application and has been actively involved as a board member ever since. The health department delivers services such as its well baby clinics, obstetric clinics, and screening programs for tuberculosis. In addition, the health department has provided limited home health services, WIC, and limited transportation services that until recently have been used primarily for transporting patients to health department clinics. The primary coordination efforts between BRMC and the NCDOH have included screening of migrant workers, and interagency referrals for maternal and child health services. More recently the health department and BRMC collaboration has increased as a result of the Rural Outreach Grant described later in this report.

Monticello Community Action Agency (MACAA)

MACAA was founded in 1965 as the anti-poverty agency for Charlottesville-Albemarle County, MACAA services to Nelson County residents include general outreach services such as: facilitating medical and social service referrals to appropriate agencies, arranging transportation, finding funds for emergency food relief or electricity bill payments, etc. The outreach worker assigned to Nelson County has worked there for several years. She has been active with BRMC, served on the Board of Directors, other related community organizations. The agency is funded, in part, through the Federal Community Development Block Grants.

Jefferson Area Board for the Aging (JABA)

While MACCA provides outreach to community residents under 60 years of age, JABA provides similar outreach case management services to the community's elderly population. The JABA employee assigned to Nelson County serves on BRMC's Board as well. Funding is provided through federally funded Area Agencies on Aging.

Nelson County Department of Social Services

The Department of Social Services work as it relates to BRMC services is primarily to determine eligibility for and enrolls people in various social service programs, e.g., Medicaid.

Region Ten Community Services

Region Ten Community Services is a Virginia Planning District Ten agency that is responsible for planning for and providing mental health and substance abuse services. It has a local office in Nelson County.

Jefferson Area *United* Transportation, Inc. (JAUNT)

JAUNT is a public service corporation, owned by the city of Charlottesville and four other surrounding counties, that was organized to provide transportation for a consortium of human service agencies. JAUNT is funded through federal grants to the Virginia Department of Transportation.

University of Virginia Nursing School

The University of Virginia Nursing School routinely utilizes BRMC as a training site for clinical rotations for its nurse practitioner students

American Medical Student Association (AMSA)

For the past five years AMSA has referred students to BRMC. These students work on health promotion and disease prevention for the Center.

United Way

The United Way contributed $3,000 in 1992 towards transportation services and health promotion designed to promote access.

CHAPTER III: COORDINATION EFFORTS

In this chapter, we begin by presenting the general characteristics that typify all of the coordination efforts of those agencies and then describe the individual coordination efforts themselves. In reading about BRMC's coordination efforts, it is important to realize that BRMC is a relatively new center, having opened its doors in 1985. Many of the coordinating agencies and organizations that are involved in collaborative efforts with BRMC were originally involved in efforts to get the clinic started and funded. In addition, may of the these agencies and organizations have been active on BRMC's Board since the clinic's inception.

3.1 Factors that Characterize BRMC's Primary Care Coordination Efforts

We found the following characteristics to typify BRMC's primary care coordination efforts.

- **Coordination projects were developed to respond to unmet/underserved community needs.** Projects were organized to address existing and unmet medical and social needs in the community needs that no single agency alone could meet.

- **In general, individuals from all agencies involved in primary care coordination projects hold positions on BRMC's governing board; where their terms had expired, they were still active on Board committees.** Participating agency involvement on BRMC's Board began from the Center's inception, The local health department has an official seat, while other members hold positions in their individual capacity.

- **Participating agencies at BRMC are small, often with only one or two employees serving community residents.** For example, MACAA and JABA are multi-county agencies with one employee working in Nelson County.

- **Projects are characterized by informal agreements.** Except for the Rural Outreach Grant that as described later, is characterized by more formal agreements, most coordination efforts are typically based on informal referral relationships.

- **By and large the success of coordination efforts is not measured by formal evaluation criteria.** Except for the Rural Outreach Grant, success was generally measured in terms of utilization. More formal measures of outcome were not generally used.

- **Coordinating transportation services to provide services to more isolated community residents was a key component of many of the coordination efforts.** In BRMC's isolated community the lack of transportation was a key access issue that was raised during nearly every interview. Talk of coordinated services was invariably tied to how to ensure transportation and thereby access to those services.

3.2 Principal Primary Care Coordination Efforts

We begin by describing the more formal relationships, characterized by agencies and organizations meeting to achieve specific goals; for example, working together to obtain funding for rural outreach services. We then describe some of the less formal relationships that are often characterized by ongoing informal referral networks; for example, BRMC referring patients to the Health Department's WIC program.

Rural Health Outreach Program

A consortium of six agencies, BRMC, the MACAA, JABA, Region Ten Community Services, Nelson County Health Department, and Nelson County Department of Social Services, received a federal Rural Health Outreach grant to fund three outreach workers whose primary purpose is to facilitate access and coordination across varied health and social service agencies. The outreach workers include a case manager (N.P. or R.N.), a service coordinator (L.P.N) and a community organizer who travel into the community conducting individual needs assessments, referrals, direct screenings and home health care to populations who are isolated geographically and culturally; low income; low literacy; elderly; and those homebound physically or by lack of transportation. The Service Coordinator particularly focuses on transportation problems, while the community organizer is working to develop local coalitions within individual areas of the county.

This project is the first formal effort involving more than two agencies. The interagency council includes representatives of the participating agency and meets monthly. The Council has several explicit goals related to the project, in addition to a general oversight role include working together to identify ongoing needs and potential ways to address them. For example, the Council is grappling with issues of confidentiality in exchange of information among agencies. Some interviewees see the Council as the beginning of a new phase of collaboration — moving beyond informal and/or two-party agreements to a more organized system.

Service Integration Grants

The Virginia Primary Care Association and the State Health Department developed an integrated services grant program to promote working relationships between the health department and community health centers. BRMC has developed two programs through this grant program. The first responded to a state senate bill requiring each county to conduct a primary care needs assessment. BRMC worked with the local health department to obtain

funding through the service integration grant for a community needs assessment that they subcontracted to the Thomas Jefferson District Planning Commission to perform. The purpose of this assessment was to identify needs for outreach services, health risk behaviors, options for modifying behavior and special needs of migrants, From this needs assessment came several ideas for potential collaborative efforts between BRMC and the Health Department including the "Walking Project" (see below). In addition, the information was used to document needs for the Rural Health Outreach Grant.

The second program was a joint BRMC-Health Department application for funding for an outreach worker to increase EPSDT for children. This project entailed working with the Health Department and Department of Social Services. The project also involved developing a form for use by the outreach workers.

Growing Younger

This project was jointly developed by BRMC and a health educator at the District Health Department. The program focused on health education and exercise for services modeled on a project conducted in Boise, Idaho. BRMC provided the staff and the Health Department van to help people get to the center. The project was funded by the State, under a Health Education Replication program.

Walking Project

BRMC and the Nelson County Health Department have co-designed the Walking Project to reduce cardiovascular risk factors among the community's residents. Participants in the Project will gather in a central location and walk various distances as a group. Staff include BRMC staff, the Health Department's health educator, and local community volunteers.

Training Programs

BRMC and the University of Virginia (UVA) Nursing School collaborate to provide community training opportunities for nursing students. Nurse practitioner students complete one to two month rotations at BRMC. In addition, BRMC anticipates working with UVA's Medical School to develop rotations for medical students as a result of the AHEC which has recently been organized in the region. BRMC's Medical Director serves on the Northeast Regional AHEC Board. And finally, for the past five years, the American Medical Student Association (AMSA) has sent students to BRMC from UVA. In addition to providing BRMC with health promotion services, opportunities to expand clinical services, trainees have undertaken special projects that enhanced services. For instance, an AMSA trainee began a BRMC Health Almanac, a newsletter sent to 6,000 households in Amherst and Nelson County.

Health Fairs/Health Screenings

Representatives from various agencies, including BRMC, MACAA, JABA, the local high school, and the local and district health departments work together to promote local health fairs and screening that include blood pressure, diabetes, cholesterol, vision, cancer screens, etc.

Maternal and Child Health Programs

BRMC and the local health department collaborate to provide a range of maternal and child health services. The local health department has the funding resources to provide well-child care for children under six years and prenatal care for pregnant women. BRMC has a part-time OB/GYN who comes from Charlottesville once a month. Women with insurance are hospitalized at Martha Jefferson. Because the hospital does not have house staff who traditionally care for indigent patients, BRMC's obstetrician sends his indigent patients to UVA. Patients followed by the health department are referred to BRMC for acute illnesses or to the hospitals previously described. Health department services to these patients include immunizations, family planning, and WIC in addition to screenings. BRMC frequently refers indigent patients to the health department for family planning, because they can receive family planning devices free at the department, while because of limited resources, BRMC must send them to a pharmacy with a prescription, Conversely, the health department likes to be able to refer children to BRMC because their acute care capacity offers greater continuity.

Migrant Health Care

The local health department and BRMC collaborated to develop services for migrant workers. Efforts were started in part because a nurse who had previous experience with migrant workers in other clinics was interested in developing similar services at BRMC. The March of Dimes funded an intensive Spanish course for the nurse; the health department performed TB screens, maternity and **well child** care, WIC, etc.; and BRMC provided screening physicals and routine primary care.

Other Ongoing Coordination

A list of specific projects cannot cover the extent of the informal, on-going coordination among agencies. With a small number of agencies, each with a different major focus, interagency referrals are common. For example, BRMC relies on the home health services of the Health Department (until recently the only home health service in the county).

CHAPTER IV: LESSONS LEARNED/BEST PRACTICES OF COORDINATION EFFORT

In this chapter we described the lessons learned/best practices elucidated from this site visit. Many of the factors found to promote collaborative efforts during the first site visit to Albany also were found to promote efforts at the second as well. In addition, new factors emerged. We have organized the findings into external and internal factors that promote collaboration.

4.1 External Factors

The Availability of Resources or the Potential for *Resources*

At BRMC, collaboration was promoted because participating agencies provided resources that no one agency alone could provide. For example, while some overlap existed, collaboration between BRMC and the health department was promoted by the fact that the health department had more resource for promotion and prevention and **BRMC more resources** for primary care services.

State Initiatives

Collaboration was promoted by initiatives at the state level. State level initiatives promoted collaboration. For example, the state funded integrated service delivery grants to promote collaboration between health departments and community health centers helped to encourage specific collaboration efforts. Collaboration between the local health department and BRMC on the needs assessment resulted in the subsequent development of health promotion activities.

Programs Respond to Demonstrated Community Needs

A critical success factor for coordinated efforts was that programs responded to demonstrated community needs — needs that were often too substantial or too complex to be handled by any one organization. As with the first site visit, BRMC's successful collaborative efforts responded to community needs. In Albany many of the unmet needs that drove coordination efforts were related to substance abuse, HIV, and homeless populations. In Nelson County geographic isolation and the lack of transportation made access a major unmet need. A major reason the Rural Health Outreach Grant was funded was it responds to that unmet need by hiring outreach workers to travel through the community and close access gaps by coordinating services and transportation.

Geographic Proximity

BRMC's proximity, despite its being rural, to nearby urban centers facilitated collaborative efforts. These nearby urban areas served as a convenient source of medical and nursing trainees. In addition, having urban centers nearby made it easier to attract physicians who provided the primary care services that were an essential component of many of the coordination efforts.

4.2 Internal Factors

Strong Leadership

As with the first site visit, strong leadership was cited as critical to the growth of collaborative efforts. Strong leadership was characterized by training and expertise, in addition to the ability to get results, promote open productive communication networks, and inspire trust both internally and with external constituents.

The *Ability to Look Beyond Turf Issues*

Interviewees related that a key success factor was that even where potential conflicts existed, participating agencies looked beyond their own self-interests to fill service needs. A willingness to participate in coordination efforts was facilitated by the understanding that each agency would come to the table to find ways to expand access even where it meant that some service overlap would exist. For instance, with the expansion of maternal health services, potential conflicts existed between the health department and BRMC regarding referral relationships. Communication and the desire of both organizations to expand maternal services minimized these conflicts and promoted referral relationships.

Home Grown Personnel

Many interviewees related that projects were successful because key personnel were from the community. Interviewees related that many of the projects relied on only one or two key personnel. Often these personnel grew up in the local community and had extensive pre-existing networks that facilitated outreach efforts and minimized the distrust that strangers knocking on doors were likely to engender. In addition, interviewees related that having grown up in the community made participants much more vested there.

Efficient Clinic Operations

Physicians related that collaborative efforts worked in part because coordinating activities and general clinic operations were efficient. This efficiency allowed physicians to concentrate on providing clinical services whereby the more patients they saw the more they could ultimately refer to coordination efforts. In addition, physician confidence

in the efficiency of collaborative efforts and in the value of the services these efforts provided, increased the referrals they made to these programs.

Pre-existing Referral Networks

As with the prior site visit, pre-existing referral networks were critical to the development of new efforts. In devising new services, pre-existing relationships made it easier for agencies to identify service gaps. For example, staff from different agencies worked together overtime to coordinate services for outreach, These historical relationships facilitated efforts to expand coordinated services through the Rural Health Outreach Grant.

The Ability to Leverage *Limited* Staffing Resources

Limited staffing often led to the development of coordinated programs. Increasing demand for services at a time when resources are more constrained, has led staff at BRMC and the local health department to look to collaboration as a way to leverage limited resources. In addition to major new staffing resources through the rural health outreach grant, BRMC has at time supplied physicians and nurses to staff health department clinics on an emergency basis when those clinics are short staffed.

Broad Involvement of Participating Agencies on *BRMC's Governing Board*

Many interviewees related that collaborative efforts were promoted by the fact that many participating agencies were members of BRMC's Board and were involved in the original grant application to start BRMC. In fact, BRMC's bylaws have provisions that provide a standing seat on the Board for a member of the local health department, which has historically and continue to view BRMC as providing a vital component of the community's primary health services. This formal forum for participating agencies may be particularly important, as geographic isolation makes frequent informal collaboration more difficult.

Involvement of *Staff* with Broader Experience and Perspectives

In some instances, projects were initiated by staff recruited from other parts of the country. These staff members brought new perspectives on alternative ways to deliver services; the nurse who initiated the migrant health program, for example. Therefore, while recruiting staff from the community facilitated efforts in some instances, recruiting from outside the community helped as well.

Staff Cross-fertilization

Collaborative efforts were promoted when staff left one agency to work with other related agencies. In one instance, collaboration was promoted when a nurse member at BRMC left to work with the health department. Her familiarity with BRMC operations enhanced BRMC/health department networks and referral relationships.

Program Development at the Health Department was *Impeded by* Budget Constraints and a Less Entrepreneurial Approach

Interviewees related instances where coordinated service development between BRMC and the health department was facilitated because BRMC's organizational structure, as compared to the health department's, provided more flexible opportunities for development. For example, foundations were more likely to give grants to BRMC than to a health department. Given the health department's budget constraints, it was easier to develop new staff positions at BRMC.

Summary

In summary, a host of factors contributed to the success of collaborative efforts in Blue Ridge. Key among them include:

- No single factor alone made collaborative efforts successful. Rather success was the result of a combination of factors such as strong leadership, broad involvement of participating agencies on BRMC's Board, etc.
- The focus of BRMC's collaborative efforts differs somewhat from the focus of successful collaborative efforts in more urban communities. What efforts have in common is that they both respond to the local, somewhat unique, unmet needs of their communities.

APPENDIX C: HIDALGO COUNTY, TEXAS

APPENDIX C:

HRSA PRIMARY CARE COORDINATION
CASE STUDY SITE REPORT

HIDALGO COUNTY HEALTH CARE CORPORATION
PHARR, TEXAS

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TABLE OF CONTENTS

CHAPTER I: INTRODUCTION

This case study report examines the coordinated primary care projects of the Hidalgo County Health Care Corporation (HCHC) in Hidalgo County, Texas. HCHC was established to provide health care to the medically indigent population of the communities along the Texas-Mexico border in Hidalgo County. The HCHC operates and provides primary health care in four locations in Hidalgo County — a primary community health center and three satellite locations. It receives Health Resources and Services Administration (HRSA) funding through Sections 329 and 330 of the Public Health Service Act: Migrant Health Centers and Community Health Centers.

To help develop the context for HCHC's coordinated primary care programs in Chapter I we provide an overview of the Hidalgo County community. The Hidalgo County Health Care Corporation and the organizations with which it collaborates are discussed in Chapter II. A general description of their coordination efforts follows in Chapter III. Chapter IV summarizes the "Lessons Learned and Best Practices" elucidated during the case study.

The Community

The Hidalgo County Health Care Corporation is located along the United States-Mexico border of Texas. Considered a large rural county, Hidalgo County contains nearly 1,600 square miles. It is bordered on the south by the Rio Grande River, and by the counties of Willacy and Cameron, to the east, and Starr, to the west. These counties comprise what is known as the Lower Rio Grande Valley. As one would expect, the county's major communities are located in the southern part of the county, near the Rio Grande waterway. HCHC's four community health centers are dispersed through the county ranging from nine to 17 miles apart.

Demographics *of* Community *and* Center Users

The Hidalgo County Health Care Corporation estimates the 1990 population of Hidalgo County at approximately 393,000. The population increased about 50 percent in the last decade. The county is one of Texas's poorest, with more than 15 percent unemployment for the year 1990. HCHC reports that 47.4 percent of county residents live below the federal poverty level. In addition, the county has a relatively young population; the average age is 22 and there is a high birth rate.

Approximately 85 percent of county residents are Hispanic, almost exclusively Mexican-American; many are monolingual Spanish-speaking. There are few Black residents of the area; in combination with other non-Hispanic minority groups, they comprise less than one percent of the area's population.

Many of the county's impoverished residents live in "colonias" that are dispersed on both sides of the Texas-Mexico international boundary. Colonias are clusters of dwellings in isolated areas outside municipal jurisdictions. These physically and legally isolated localities suffer from abject conditions of poverty including substandard housing, inadequate plumbing and sewage disposal systems, inadequate access to clean water, unemployment as high as 50 percent, rampant chronic diseases, inadequate health insurance and education, poor prenatal care, and school dropout rates of close to 50 percent. Colonias are most prevalent in the Lower Rio Grande Valley, although they also appear in the West Texas county of El Paso.

The Hidalgo County Health Care Corporation FY 1992 Section 330 Continuing Funding Application estimates that 20,440 users will receive HCHC care this year. Ninety-eight percent of users are Hispanic; 90 percent live below the federal poverty line; and 90 percent are not covered by any form of health insurance. Medicaid and Medicare recipients comprise nearly all of the remaining 10 percent, as only 0.2 percent of users have private insurance. Slightly more than one-fourth of clinic users are migrant and seasonal farmworkers. Many of these workers live in the destitute rural colonias. In fact, one of every five HCHC users is a colonia resident. A special consideration for HCHC clinics is the large population of women of childbearing age who comprise 38.4 percent of HCHC users.

Local Economy

Climate and geographical factors support a local economy that is primarily based on retail trade, agriculture, labor-intensive industry, and tourism. The Rio Grande Valley Chamber of Commerce reports that 20.5 percent of Valley residents are employed in the trade sector, also supported by patronage from Mexican nationals. Hidalgo County's temperate climate and irrigation system allow for year-round agricultural production. The county's major crops include cotton, citrus, grain, vegetables, and sugar cane; major processing plants have developed around these agricultural products. Supplementing agricultural industries, electronic assembly, machine manufacturing, and other plants employ 9.5 percent of the population in the manufacturing sector. Texas's moderate climate promotes tourism which supports the local economy as well. Every fall, Hidalgo County draws approximately 80,000 "Winter Texans", Canadians, Minnesotans, and other Midwesterners who either reside in Hidalgo County for the winter months or simply come to visit.

Health Status and Special Health Needs

The major problems experienced by HCHC patients of all ages are typical of indigent populations throughout the country. Among children and adolescents, bronchitis, otitis media, and URI are the most frequent diagnoses; among adults and the elderly, diabetes and hypertension generate the most frequent encounters. However, the county also has higher-than-average incidences of tuberculosis, Hansen's disease and cervical dysplasia. Among perinatal users urinary tract infections and iron deficiency anemia are common diagnoses.

Hidalgo County faces particularly difficult issues in addressing the health problems of migrant and seasonal farmworkers. Health problems endemic to the indigent are exacerbated

by the geographic isolation of colonias, cultural barriers (e.g., language), and poor education. Furthermore, it was related that a stoicism exists among male agricultural workers that often deters their seeking the care of a physician until problems become more severe and difficult to treat than they might otherwise be.

Although HIV+/AIDS patients account for less than one percent of HCHC users, this issue deserves special consideration. The health risks of AIDS are magnified by the prevalence of prostitution and drug use in the area and the continuous flow of persons who enter the county after having been diagnosed elsewhere.

Primary Health Care *Delivery System*

The Hidalgo County Health Care Corporation, a major provider of primary care to the indigent, the Hidalgo County Health Department, area hospitals, and private physicians all provide care to the medically indigent population of Hidalgo County.

The Hidalgo County Health Corporation is described in more detail later in this report. It is the main provider of primary care to the medically indigent in Hidalgo County. The Hidalgo County Health Department maintains several public health clinics that provide categorical care or infant and maternal services. The Health Department does not operate full-service comprehensive primary care centers. H.D. clinics, staffed by nurses and nurse midwives, provide mainly prenatal care screening, immunizations, family planning, referrals, and health education, and are located in Donna, Edinburg, Elsa, Hidalgo County, La Joya, Pharr, Mercedes, Mission, and Weslaco. Hidalgo County also supplies a mobile nurse clinic that visits colonias to provide screening and basic health care and make referrals. Unlike some other Health Departments, the Health Department in Hidalgo County has not traditionally provided mental health/mental retardation services due to a lack of resources even for those programs considered of higher priority.

Local hospitals include the McAllen Medical Center, Rio Grande Regional Hospital (in McAllen), Mission General Hospital, Edinburg General Hospital, and Knap Hospital (in Weslaco). With the exception of Knap, all of these are for-profit hospitals. Many of the for-profit hospitals were originally not-for-profit hospitals that were taken over by for-profits when they were no longer financially viable. Many interviewees stated that access to acute care for the indigent has decreased as a result. The hospitals claim to be losing $3.5 million on services to Medicaid recipients and are reluctant to serve either Medicaid or the uninsured. Most patients are hospitalized at McAllen Medical Center, which is the area's largest hospital. It maintains a neonatal intensive care facility and therefore receives greatest number of perinatal emergency care visits.

Private physicians in Hidalgo County are generally reluctant to accept indigent patients, especially because they perceive that the indigent are more likely to sue than the insured population, However, no hard evidence exists to support this perception. Indigent patients may also opt out of the primary care system by seeking care in Mexico or by relying on non-traditional providers.

Summary

Because of the Hidalgo County's proximity to the Texas-Mexico border, its medically indigent population consists almost exclusively of Hispanic, Mexican-American residents, the majority of whom have no health insurance coverage. The challenge of providing health care to this group is that of serving a dispersed, rural population that is often physically isolated, as are the colonias, or culturally isolated from the sources of health care. The table on the page summarizes community and HCHC users' data.

SERVICE AREA AND USER CHARACTERISTICS OF THE Hidalgo County Health Care Corporation*

	SERVICE AREA [PERCENT]	USERS [PERCENT]
Race/Ethnicity		
White [Non-Hispanic]	14.1	1.3
Black/African-American [Non-Hispanic]	0.1	0.2
Hispanic/Latino [of any race]	85.2	98.3
American Indian & Alaskan Native	0.1	N/A
Asian/Pacific Islander	0.2	N/A
Other	0.2	0.2[3]
Income		
At or below Poverty Level	47.4	90.4
101-l 50% Poverty	34.3	7.7
151-200% Poverty	18.3	1.9
Insurance. Status		
Medicaid	12.8	5.4
Medicare	8.6	4.5
Other	3.1	0.2
None	75.5	89.9
Special Population		
Migrant Farmworkers	30.7	21 .o
Seasonal Farmworkers	23.8	7.4
'Colonia' Residents	12.5	19.3
Females of Childbearing Age	43.7	38.4
HIV+	0.2	0.09

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[2] This chart has been adapted from the 1992 Hidalgo County Health Care Corporation Section 330 Continued Funding Grant Application.

[3] This figure represents the combined percentage of American Indian & Alaskan Native, Asian Pacific, and Other HCHC users.

CHAPTER II: DESCRIPTION OF LEAD AND OTHER AGENCIES/ORGANIZATIONS THAT PARTICIPATE IN PRIMARY CARE COORDINATION EFFORTS

2.1 Hidalgo County Health Care Corporation

Incorporated in 1973, the Hidalgo County Health Care Corporation consists of four health centers, a central clinic and three satellite clinics, all of which are located along the southern edge of Hidalgo County, near the United States-Mexico border. Under the direction of the Executive Director, Frank Vasquez, the Health Care Corporation oversees and manages the business affairs for the four centers: the Pharr Family Health Center, Mercedes Family Health Center, Delta Rural Health Center, and Mission Family Health Center. The Pharr Family Health Center is the primary clinic. The administrative office is also located in this center.

The services that Hidalgo County Health Care Centers offer include:

- Primary medical services
- Diagnostic lab and x-ray
- Preventive health services including: immunizations, family planning, vision and hearing screening, and social services
- Eligibility determination services
- Financing of inpatient care for migrant farmworkers
- Pharmacy
- Emergency medical
- Transportation
- Referral services to supplemental service providers and hospitals
- Case management services
- Health education
- Disease screening
- and Translation services,

The by-laws of the Hidalgo **County Health Care Corporation stipulate that** HCHC be governed by a Board of Directors and Executive Director. The Board is a policy-setting entity

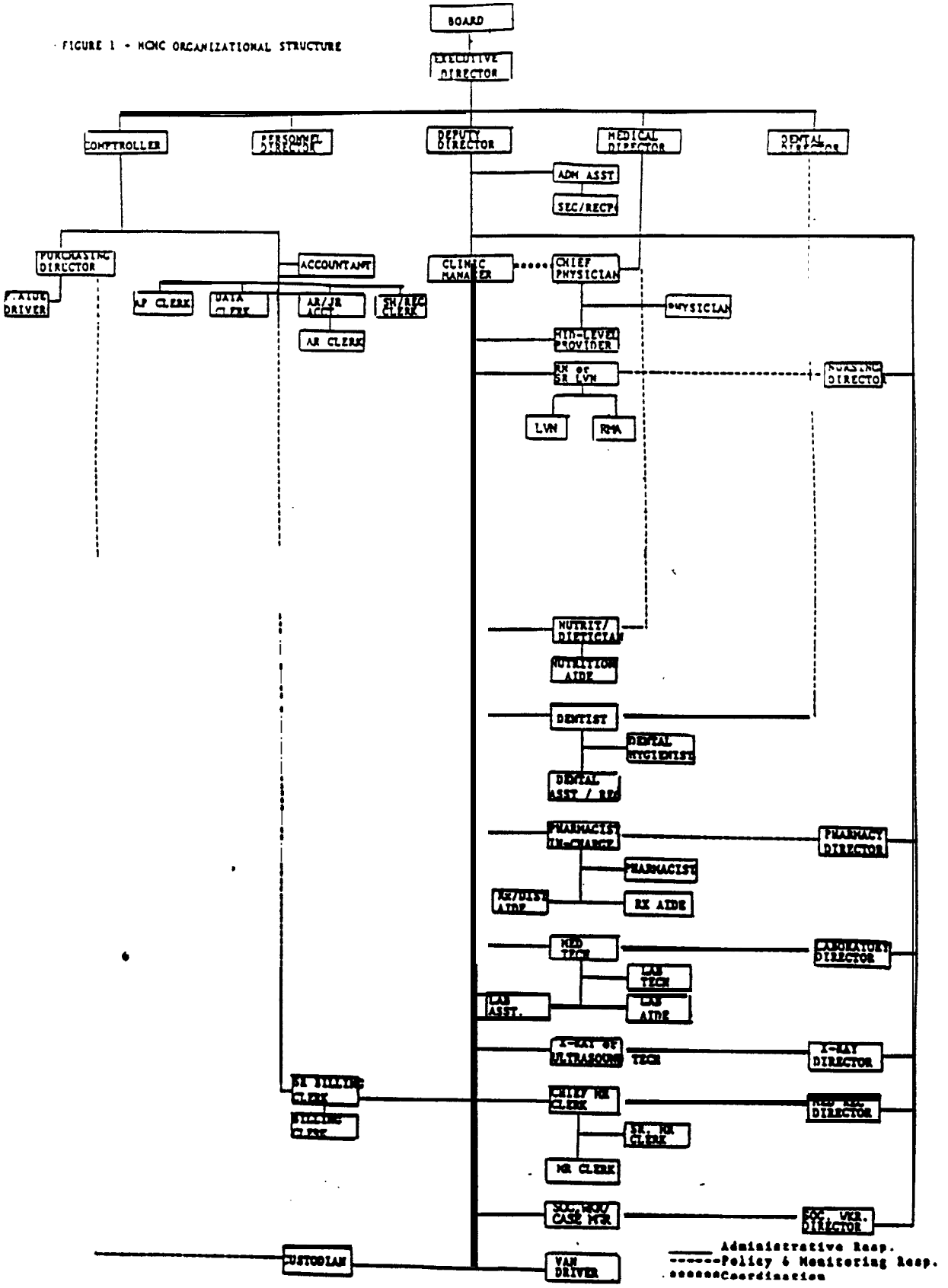
responsible for establishing corporation goals and objectives and monitoring progress toward them. It is currently composed of nine users and six non-users. Users represent the three satellite clinics as well as the primary center. Five of the current user-members represent migrant and seasonal farmworkers. During the next election, HCHC will implement a plan to reduce the high proportion of migrant workers so that the Board will be more reflective of the proportion of all patients served by the HCHC system.

The Executive Director of the Hidalgo County Health Care Corporation is Frank Vasquez. He and his Deputy Director, Roy Becker, are charged with the daily management of the HCHC and oversight of its four health clinics as well as the supervision, organization, and implementation of the long-term planning for HCHC operations. In addition to these persons, the administrative staff includes a Personnel Director, Comptroller, Medical Director, and Dental Director. Each clinic site is directed by a Clinic Manager, who is responsible for the non-clinical administration of that center and for coordinating with the center's chief physician on clinical issues. Each of these satellite centers is organized similarly with a clinic manager who reports to the Deputy Director of the HCHC. Functional reporting relationships exists between professionals across the health centers. For example, the nurses at the respective clinics report to the Director of Nursing of the HCHC and provide health care to similar populations. The HCHC develops and oversees an annual operating budget for all member clinics. A copy of HCHC's organizational chart is included on page C-9.

HCHC generates revenue from federal, state and private grants in addition to patient billing. On the next page appears a table detailing HCHC's projected 1992 revenues, which total approximately $6.23 million. Nearly 24 percent of this sum is generated by patient revenues. HCHC reports that it obtains $0.86 million from third party insurance and self-paying patients. Medicare and Medicaid account for roughly $100,000 and $530,000 income, respectively. Further revenue is generated by grants to the Texas Primary Care Program, Migrant Hospitalization Program, Coalition for AIDS Service Enhancement Program, and Breast and Cervical Cancer Control Program,

PROJECTED 1992 REVENUE - HCHC		
Patient Revenue		
MEDICARE	$ 99,859	
MEDICAID	530,139	
Self-Pay/Third Party Insurance	863,755.	
Total Patient Revenue		**1,493,753**
Combined Section 329 & 330 Grants		**3,719,462**
State and Private Grant Revenue		
Texas Primary Care Program	311,793	
Migrant Hospitalization Program	40,000	
CASE Program	401,255	
Breast and Cervical Cancer Control Program	64,532	
Integrated Eligibility	75,000	
Total State & Private Grant Revenue		892,580
Other Income		
Texas Migrant Council	7,000	
Medical Information	2,000	
Cuvettes	500	
Interest Income	**2,000**	
Rent Income	9,600	
Medicare Cost Settlement	50,000	
Medicaid Cost Settlement	50,000	
Space-In-Kind	36,000	
Total Other Income		**157,100**
Total Projected Revenue - 1992		**$ 6,262,895**

Figure 1
Organizational Chart for Hidalgo County Health Care Corporation



2.2 Other Participating Agencies

Hidalgo County Health *Department*

The Hidalgo County Health Department provides a range of services for: maternal and child health, sexually transmittable diseases, tuberculosis, cancer screening, and family planning. The department historically has lacked the resources to provide mental health/substance abuse programs and refers related problems to area public and private providers; it was generally acknowledged that there is a shortage of these services.

Two-thirds of the Health Department's budget comes from the state and one-third from Hidalgo County. Over the last five years the Department's state funding has decreased; county funding has increased slightly. The Director of the Health Department related that the Health Department's reliance on the community health clinics for primary care has increased over the last few years particularly given the Health Department's funding cuts.

McAllen Medical **Center**

The McAllen Medical Center (MMC) is the largest and most centrally located hospital serving the clinics of the Hidalgo County Health Care Corporation. It is an approximately 300 bed private hospital which, according to the 1991 American Hospital Association Guide, recorded greater than 13,000 admissions in 1990. Its service capabilities include inpatient care for AIDS/ARC; surgical services; an intensive care unit; cardiac surgical and rehabilitative services; a range of psychiatric services; outpatient therapeutic services; technologies, including CT scanner, MRI, and SPECT facilities; and maternal and child health services, including a neonatal intensive care unit.

The recent take-over by a for-profit chain, resulted in MMC's decreased willingness to accept absorbing the costs of health care to the indigent. In addition, interviewees relate that the hospital's security guards until very recently wore uniforms that looked similar to those of immigration officers which discourages indigents as well. While HCHC physicians have maintained privileges at McAllen Medical Center, they are encouraged to consider obtaining privileges at other area hospitals in order to distribute their hospital inpatient care more evenly. Due to its obstetrical services and neonatal intensive care unit, however, McAllen Medical Center does remain the principal hospital for obstetrical care for Health Corporation physicians.

Planned Parenthood Association of Hidalgo County

Planned Parenthood has been providing women's health care to Valley residents for about 27 years. In addition to the usual family planning services, the agency provides preventive and treatment services (e.g., breast examinations and Pap tests for post-menopausal women, treatment of urinary tract infections). They refer patients with more significant medical problems to private physicians and to HCHC.

University of Texas *Health* and Sciences Center

The Health Sciences Center (HSC) is a San Antonio-based teaching and research facility of the University of Texas, whose medical education facilities are located at the University's main campus in Austin and in major cities throughout Texas. The university's San Antonio campus includes Schools of Dentistry, Medicine, and Nursing, and Programs in Occupational and Physical Therapy, and Blood Bank Technology.

In the Hidalgo County area, the San Antonio Health and Sciences Center, which is a member of the University of Texas Health and Science Center System, operates three major activities, In a Pharr, TX facility located adjacent to HCHC offices, the Health and Sciences Center operates a Pediatric Specialty Clinic, staffed by UT physicians and residents. The clinic provides specialty care especially to chronically ill children, including such services as pediatric rheumatology, neurology, pulmonary medicine, and AIDS services. During the summer, HSC's mobile dental unit circulates the Hidalgo County area providing dentures for area residents. The San Antonio Health and Sciences Center is also the main institution of higher education selected by the Lower Rio Grande Valley Area Health Education Center (which will be discussed later in this report), It addresses the shortage of local physicians by rotating residents through the HCHC health centers.

Valley AIDS Council

The Valley AIDS Council is a consortium of valley health care providers originally organized in 1990 to provide AIDS prevention and education. The council received its first funding in December of that year. Since that time through additional funding the council also provides case management through the "CASE" program described in more detail later in this report. The Valley AIDS Council receives funding from the Texas Department of Health, the Center for Disease Control, the United Way of Brownsville, the American Red Cross, Ensure, and Ryan White. The AIDS council refers patients requiring primary care to community health centers,

Other *Community* Health Centers

In addition to the HCHC centers, three other community Health Centers operate in South Texas and participate in many of Hidalgo County's coordination efforts, They are the Su Clinica in Harlingen, Texas and the Brownsville Community Health Center in Brownsville, Texas, and Community Action Council of South Texas in Rio Grande City, Texas.

Lower *Rio Grande* Valley Area Health Education Center *(AHEC)*

The primary purpose of the AHEC is to provide more primary health care services and educational resources to the Valley while providing educational opportunities to students from the University of Texas Health and Science Centers. The AHEC's funding from the Department of Health and Human Services is $3 million for three years. Members of the AHEC include the University of Texas (the administrator of the AHEC is the University of Texas in San Antonio), all of the area community health centers, the County Health Department, and area hospitals.

AHEC programs include a wide range of medical, nursing and ancillary training programs. Medical programs include a variety of medical student and resident training programs in addition to funding for the pediatric subspecialty clinics described below. There are currently clerkships and rotations for third- and fourth-year students in family practice, internal medicine, and pediatrics and dentistry. The AHEC covers transportation and living expenses during the placement.

Nursing programs include shared faculty arrangements between UT San Antonio's nursing school and nursing schools in the valley. Nursing programs include shared faculty arrangements between UT San Antonio's nursing school and schools in the valley. The Valley suffers from a shortage of nurses, and there is an intensive effort to prepare nurses at the masters level, so that they will be able to enhance available faculty at the nursing school in Edinburgh. Under various cooperative agreements, students will be able to attend school for 13 weeks and then work 13 weeks. Many of the classes are held on a Friday-Sunday schedule, so that students can continue to work. The first group of students in this program will graduate in August. It is hoped that they will remain in teaching rather than return to work in hospitals.

The AHEC provides funding for a two-week program in San Antonio for Valley High School students interested in healthcare careers. This "Health Careers Opportunity Program" provides interested students with a broad exposure to careers in laboratory technology, radiology, medical records, etc. with the hope that students that go onto pursue those careers will ultimately return to work in the Valley. Students spend two weeks at UT San Antonio under this program.

Breast and Cervical Cancer Control Program *(BCCP)*

A consortium including HCHC, the County Health Department and Planned Parenthood Association of Hidalgo County was formed to provide comprehensive breast and cervical cancer screening to low-income women over the age of 40. The consortium was developed because various research efforts and needs assessments have identified a high incidence of cervical dysplasia in the community which often goes untreated. Funding for the

program is provided through the CDC and Texas Department of Health. The Rio Grande Radiation Treatment & Cancer Research Foundation donated a colposcope and other miscellaneous equipment to the clinic. Planned Parenthood contributed a grant writer to help prepare the application and currently donates the time of one of their nurse practitioners to help staff the clinic. The BCCP clinic operates at HCHC's Pharr facility, HCHC performs mammograms and colposcopies. Cryotherapy is performed for clinic patients at the Health Department because the Pharr dysplasia lacks adequate space for cryotherapy equipment. Referrals originate from all members of the consortia in addition to other health care providers.

University of Texas (U.T.) System Valley/Border Health Services

The U.T. System Valley/Border Health project was developed by U.T.'s Vice Chancellor in part because the Valley/Border community was concerned that "community residents were being researched to death" but saw little in the way of improved health care resources as a result of that research. The U.T. System Valley/Border Health Services staff plans to develop an inventory of the research projects in the valley, to facilitate more coordination across research projects and to help ensure that projects result in the development of substantive educational and technical assistance efforts to needs issues identified. The Border project has an office in Edinburg to facilitate coordination between U.T. and local health care organizations around program development and collaborative responses to RFPs. Non-UT. Organizations that participate in the Valley/Border health project include: local, regional, and state agencies; community health centers; and other health institutions.

One of the efforts of the Valley/Border health care project was a Valley/Border Health Symposium in 1990 that included presentations on the myriad of U.T. health care projects conducted in the Valley. Participants included representatives from U.T., and other health care providers in the Valley including the Executive Director of HCHC.

***Pediatric Subspecialty* Clinic**

HCHC through its affiliation with the University of Texas Medical School at San Antonio (UTHSC-SA), developed Pediatric Subspecialty Clinics based at HCHC's Pharr Clinic tiiat is primarily staffed by UTHSC-SA pediatric subspecialists. Other participants in the pediatric subspecialty program include Harlingen Pediatric Associates (a private physician group that follows children from the clinic who are admitted to local hospitals), and Valley Baptist and South Texas Hospital. Pediatric subspecialists include pulmonologists, infectious disease specialists, endocrinologists, rheumatologists, hematologists, and neurologists.

In many cases, these pediatric subspecialists represent the only specialists available in the area. Therefore, while the services were developed for indigent patients, subspecialists see private referrals as well.

Operating funds for the specialty clinics are provided through Texas Department of Health's program for "Critically Ill and Disabled Children." The AHEC reimburses related physician travel expenses. The physicians are salaried by U.T.

Though the clinic is physically located at HCHC's Pharr Clinic, it leases space from HCHC and is run autonomously and the Pharr Clinic patients are not automatically enrolled as Pharr clinic patients, A shortage of physicians at the Pharr clinic has created a waiting list for new patients, and unless an emergency occurs pediatric subspecialty patients are queued like other potential new patients.

Valley ***Interfaith***

Valley Interfaith is a not-for-profit group that has worked with local community health centers and hospitals, local business leaders, and Texas State legislatures to increase access to the uninsured by developing a managed care package initially for between 3,000 to 3,500 people, HCHC, UT. Pan American, Hidalgo County Health Department, and other local community clinics have been active participants in designing the program, including assessing the resources that would be required and what resources are currently available.

Valley Interfaith is a community-based organization, centered around 42 parishes and churches in the area. Their mission is, broadly, to improve the overall well-being of residents in the Valley. The program is part of the network of the Texas Industrial Areas Foundation — an offshoot of Saul Alinsky's community organization efforts.

Valley Interfaith attempts to organize along a variety of fronts, including education, sanitation, and health issues, They have been actively involved in efforts to obtain state funding in order to build sewers in the colonias. Regarding health care, they have worked with health agencies, including HCHC, to develop the "Valley Care" proposal. This proposal is for a Valley-wide network, including the local Health Departments, community health centers, and other providers, which would provide financing coverage and services for uninsured residents. The proposal, currently in its conceptual stages, involves developing a subsidized insurance plan which put emphasis on prevention. Initially, it could cover about 3,000 people.

Denture Program

!n 1989 HCHC developed a collaborative agreement with UTHSC-SA and San Antonio Dental School to provide dentures for edentulous elderly patients. During the first year of service over 40 sets of dentures were provided; that number doubled during the second year. Dentures are provided through a mobile van stationed outside of the Pharr clinic for two months during the summer. In addition to providing needed dental services, the dental school eager to provide these services as training opportunities for its general dentistry residents and dental hygiene students. Funding is through the dental school.

Coalition for AIDS Service Enhancement (CASE)

HCHC serves as the lead agency for a Valley wide consortium to serve AIDS patients. The Consortium includes 80 people from about 30 agencies. Other members of the

consortium include Brownsville Community Health Center, Su Clinica Familiar, Community Action Council of South Texas, South Texas Hospital, the Valley AIDS Council, and HCHC.

The project began when Bureau of Primary Health Care (BPHC) funding became available to support primary care services for AIDS patients. HCHC and the Valley AIDS Council explored the possibility of developing an application for these funds. As a result, HCHC helped to develop a consortium, including all three community health centers in the Lower Valley (HCHC, Brownsville, and Su Clinica) which applied for and obtained funding. The project covered the cost of drugs and other primary care associated expenses; physician time was to be contributed by the centers. With enactment of the Ryan White CARE Act, the funding source has shifted to Ryan White dollars. The project is now in its second year of funding.

Over time, HCHC has become the lead agency for the AIDS project. Respondents indicated that the three community health centers are, generally, understaffed and overwhelmed. One has been unable to accept new patients, due to space and staff clinical limitations. While Valley AIDS Council provides case management and crisis intervention services, and contracts with a private agency for home health care, the Council does not provide direct medical services.

Board-Training Program

HCHC worked with the National Council of La Raza (NCLR), a non-profit advocacy agency for Americans of Hispanic descent, to develop a training course for HCHC's Board members. This course was provided by NCLR at no cost to HCHC. While not a "primary care coordination project" in the traditional sense, this collaborative effort between NCLR and HCHC was designed to increase the Board's ability to work productively in providing strong strategic direction for HCHC. HCHC's Executive Director related that Board training is increasingly important to ensure that members have the requisite skill base required to oversee center operations and ultimately to promote primary care delivery.

CHAPTER IV: LESSONS LEARNED BEST PRACTICES OF COORDINATION EFFORT

In this chapter, we describe the lessons learned/best practices elucidated from this the fourth of the six site visits. Where our findings include factors identified in previous site visit reports, they are reviewed more briefly here. More discussion is included around those findings that are new or that have not previously been elucidated. As previously discussed, the final report will tie together the findings across site visit reports and highlight the implications of the findings. We have organized the findings into 1) external factors, i.e., those that are related to local community, state or national characteristics, and 2) internal factors, e.g. those related to operating or programmatic characteristics.

4.1 External Factors

The *University of Texas* ***Health*** **Sciences** *Center*

The existence of the large UT Health Sciences Center system provides a wealth of resources and opportunities for collaborative efforts at HCHC that might not otherwise exist. Many of the coordination efforts at HCHC involved collaborative efforts with various UT Health Science's Center sites, such as UT's schools in San Antonio, Galveston, UT Pan American. These schools offer medical and nursing staff, faculty appointments to attract new clinicians, funding for clinical services and through the UT Systems Valley/Border Project, a mechanism for coordinating activities across clinicians. These resources are particularly important to HCHC, given the shortage of public resources at the state and local level.

Commitment *and* **Concomitant Funding** ***by*** *Leaders of University of Texas (UT)*

Major commitments by leaders of the UT Health system facilitated collaboration across providers. Over the last few years UT has been increasingly involved in Valley health care issues. The Valley is important to U.T. in providing sites for clinical training and research programs. Nonetheless, U.T.'s mission to provide more coordinated services to the valley is challenged by the geographic dispersion of the population, and the myriad of and often conflicting priorities across providers. Interviewees relate that U.T.'s involvement has been sustained despite these challenges because of the commitment of strong leaders at the medical schools and the Vice-Chancellor office.

Commitment ***by*** *Leaders of* **Local** ***Health*** *Department*

Collaboration was promoted by new Health Department leadership that looked to primary care provided by the community health centers as a way to increase, flat or dwindling Health Department resources. The head of the Health Department related that state funding of the local Health Department has been flat over the past several years despite

an increase in demand for services. For instance, though the number of reported cases of TB has doubled over the last three years, funding has not increased. The head of the Health Department viewed collaboration with other local providers as a way to combine limited resources to expand care. The head of the Health Department related that collaboration worked particularly with HCHC because neither organization viewed the other as competitive, and because the relationship was characterized by mutual respect, openness, a willingness to compromise on both sides, lots of communication and an understanding that collaboration ultimately benefitted patients.

Funding *by* National Foundations

Robert Wood Johnson Foundation funded advanced training for a nurse; training that was ultimately required to begin a new collaborative project. The valley has a shortage of trained registered nurses. One nurse, who grew up in migrant camps, was able to complete post-graduate training as a nurse practitioner because of funding by the Robert Wood Johnson Foundation. Prior to the training, she worked in the community health centers in Hidalgo County. Following her training she returned to develop and staff the pediatric subspecialty clinics (a collaborative effort between the University of Texas Medical School at San Antonio and the Hidalgo County).

National Health Service Corps (NHSC)

As **with other sites, the NHSC played a key role in collaborative efforts. The NHSC** placed a dentist and physician at Hidalgo County. The availability of these well-trained and experienced clinicians provided many additional collaborative **opportunities.**[4] The dentist was active in the Valley AIDS Council, providing dental services and advice regarding caring for AIDS patients. He is also a faculty member of UT San Antonio's dental **school and** gives regular lectures there. He also coordinates dental services across Hidalgo County. And, finally, he supervises the services of a hygienist who is active within the community.

4.2 Internal Factors

Strong Leadership

As with all other site visits, strona leadership at HCHC, the Health Department, and the University of Texas Health **and** Sciences Center was related by most interviewees as a reason that collaborative projects were successful. Strong leadership included extensive prior experience working with community health centers, solid training and expertise, and the ability to generate support and respect both internally and externally. The conscientious efforts,

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[4] **The previous medical director of HCHC, who had served in that capacity for six years, had also been supplied by NHSC. She was the essential motivator for numerous collaborating programs, most notably the CASE Project.**

experience, and managerial skills of the HCHC Executive Director were cited, particular, by many interviewees.

High Visibility

One factor promoting collaborative efforts is high visibility -wide publicity about existing services and unmet needs, for example. The Executive Director of HCHC is actively involved in health care issues at the state and national level. His presentations at various meetings have increased awareness at the local, state, and national level of the Valley's health care needs. This increased awareness has generated more interest and funding for Valley health care projects by both from the public and private sector. For example, HCHC's Executive Director has recently been invited to serve on the Executive Planning Committee to plan and develop a National Surgeon General's Hispanic/Latino Care Initiative.

Successful Networking Among Physicians

Collaboration was promoted by physicians who successfully recruited additional physicians to participate in collaborative programs. Having physicians who were enthusiastic about existing collaborative efforts was key to expanding efforts.[5] Another example is the subspecialty pediatric services in Hidalgo County provided by physicians from San Antonio were expanded as existing subspecialists recruited colleagues to staff additional clinics. This one-on-one intensive physician/physician recruitment created an awareness of and enthusiasm for services that otherwise might not have existed.

Access *to Capable* Grant *Writers*

Many examples were cited of collaborative efforts that were successful because of access to capable grant writers that had track records of successful funding. These grant writers included representatives from a number of the participating agencies and organizations, including the lead agency itself. The AIDS, AHEC, and BCCP grants are three of many projects that interviewee related were awarded because of access to experienced and talented grant writers.

Physician/Physician *Follow-up*

Interviewees related that physician/physician follow-through was one factor accounting for the success of collaborative efforts. Where physicians counted on outside physicians for referrals, (particularly for the pediatric subspecialty practice), written follow-up

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5 Medical leadership by the previous medical director at **HCHC** was especially important in generating physician support for collaborative efforts.

on consults promoted collaboration. Written follow-through by the consulting physician provided important clinical information encouraging subsequent referrals.

Board *Support*

Community Health Center Board understanding of and support for critical operational and strategic issues are essential to the success of collaborative efforts. Board sophistication may be critical to collaborative efforts. For instance, many of Hidalgo County's coordination projects require the support of a strong base of primary care physicians. This base was threatened when increases in non-competitive physician salaries were initially not supported by HCHC Board. Intensive training developed a better understanding among Board members of the importance of competitive salaries to physician recruitment and retention. In general, the Board has been very supportive of collaboration projects and recognized their importance to improving community services.

Reliance *Where Necessary on Physician Recruiting Firms*

Maintaining a strong base of primary care physicians is critical to many collaborative efforts. As a rural area, Hidalgo County is disadvantaged as compared to health centers located in attractive areas, such as Seattle, in attracting physicians. In addition to HCHC's own recruiting efforts, the administrator at Hidalgo County relied on physician recruiting firms that were successful at generating new physicians for Hidalgo County. As previously discussed, physician/physician recruiting is also a successful technique.

Pre-existing Linkages

Pre-existing linkages promoted the development of new collaborative efforts. As with previous site visits, we found that where pre-existing linkages existed, these linkages often served as forums through which new coordination projects were identified.

Facilities/Equipment

Many interviewees related the quality of facilities and equipment are important components of successful collaborative efforts. These components were viewed as important in recruiting the staff necessary for successful collaborative efforts. For instance the space dedicated to dentistry was important in the dentist's decision to practice at Pharr. This dentist was involved in many collaborative projects including: community seminars on dental care for AIDS patients, lectures at San Antonio's dental school, and local CPR classes, for example. In addition, he supervises clinical training for residents on clinical rotations at Pharr, from San Antonio's dental school.

New Grant Opportunities are Sought Proactive/y

The HCHC Executive Director looks at new grant programs as an opportunity to attract and develop more resources and services for the area. This seize-the-opportunity approach encourages others to join in these efforts to increase services. At times this proactive approach may lead to trade-off decisions to start programs before back-up systems are fully able to accommodate them. For example, though HCHC's subspecialty Pediatric Program is operational, a lack of clinicians prohibits the finalization of details with regard to referrals for pediatric primary care.

Recruitment and Retention of Key Staff

In addition to the presence of well-trained providers, capable grant writers, and strong leadership, the recruitment and retention of key staff members are critical to the success of collaboration efforts at HCHC. The corporation's grant writers, dental director, previous medical director, personnel management officer, controller, and deputy director, have all been with HCHC for more than three years. Their experience within HCHC and the community contributes to networking agreements and the smooth functioning of collaborative efforts in the county.

Summary

In summary, a host of factors contributed to the success of HCHC's coordination efforts, The support of organizations outside of Hidalgo County as well as the actions and sound program design of Hidalgo County health leaders contribute to successful coordination in the county. The University of Texas research facilities, medical schools, and funding sources enabled HCHC to staff and operate training and service delivery programs that otherwise could not have been arranged. The support of national institutions like the Robert Wood Johnson Foundation and the National Health Service Corps also facilitated program establishment and staffing. The presence of capable grant writers and active promotion of the community's needs by vocal health care leaders expedited collaboration efforts. The ability of service providers (physicians, nurses, social workers, etc.) to communicate with each other and the presence of quality equipment facilitate program efficiency and positive outcomes.

APPENDIX D: ALBANY, NEW YORK

APPENDIX D:

HRSA PRIMARY CARE COORDINATION CASE STUDY SITE REPORT

WHITNEY M. YOUNG COMMUNITY HEALTH CENTER ALBANY, NEW YORK

92LF0883

TABLE OF CONTENTS

CHAPTER I: INTRODUCTION

The purpose of this project is to discover, analyze, and communicate the lessons learned or best practices of local community coordination models with an eye to their replication in other communities, and the potential for program-level improvements. Six case studies will be completed examining the service linkages created in response to various community health needs. This study will focus on community models of coordination among Health Resources and Services Administration (HRSA) grantees and public health agencies. All sites studied will include one or more HRSA-funded agencies, which serve as the lead agency for the coordination project, and a local public health authority. Other health care organizations which are involved in the coordination efforts will also be described.

The explicit description of the evolution of relationships ultimately resulting in effective coordination services between public health agencies and a variety of HRSA and other programs must be drawn in relationship to the unique demographic and relevant political characteristics of the community. Each case study will identify and analyze the community and programmatic characteristics which support the particular model of coordination implemented by the agencies involved. The final report will synthesize the findings of the case studies and present lessons learned which may provide useful information to other grantees in their efforts to better coordinate primary care efforts.

This, the first in the series of case study reports, examines the coordinated primary care projects of the Whitney M. Young Health Center (WYHC) in Albany, New York. To help develop the context for WYHC's coordinated primary care programs, we begin in Chapter I by providing an overview of the Albany community. The history, target market, and general services provided by the WYHC are presented in Chapter II. The coordination efforts are discussed in Chapter Ill. In Chapter IV, we summarize the "lessons learned and best practices" in coordinating primary care services elucidated during the case study.

The Community

The Whitney M. Young Health Center (WYHC) is located in Albany County in the city of Albany, the capital of New York state. In addition to being the state capital, Albany City is the urban locus for a six-county area which includes Rensselaer, Columbia, Greene, Schoharie, Schenectady, and Saratoga counties. While Albany, Rensselaer, and Schenectady contain a strong urban component, Columbia, Greene, Schoharie, and Saratoga are predominantly rural communities. A county and city map of the state of New York is included on the next page. Residents from each of the neighboring six counties participate in Center programs, but the majority of clients are drawn from Albany and Rensselaer Counties. For the remainder of this report, the term service area will be **used to connote these two counties.** The Center is located in the city's Northside, the predominant low income section of the city.

Demographics of *Community and* Center Users

Nearly 100,000 of the Albany county's 285,900 residents reside within the city limits. Moderate population growth is projected for the county over the next decade, with heavier increases expected in rural areas. The population is also expected to age during the coming decade as the baby-boom generation matures. The median age of Albany county residents is expected to increase from 31.3 in 1980 to 42 years in 201 0[6].

For 1990 the Center reports that 43.5 percent of its users are White: 46.4 percent are African-American; 4.3 percent are Latino/Hispanic; and 5.8 percent are from other minority groups. This user market is significantly different from the Center's community-wide population which is reported to be 77 percent Caucasian; 16.5 percent African-American; 5.7 percent Latino/Hispanic; and 0.8 percent from neither African-American nor Latino/Hispanic minority groups.

Local Economy

The economy of Albany county is regional, including components of the Albany-Schenectady-Troy Metropolitan Statistical Area. Like other northeastern urban centers, Albany is experiencing economic and social hardships; however, the county is economically grounded in the government sector and more recently has been buoyed by private interests. The socio-economic conditions of the Center's target market are strikingly grim. Nearly three of four Center users' incomes are below the federal poverty level. The Center reports that 45 percent of households in the primary service area have an income less than $25,000, or less than 200 percent of the poverty level. In 1980, nearly one-quarter of the county's children were below the poverty level compared to 10.2 percent of the overall population. This figure is expected to have worsened over the past decade.

Many Health Center users lack private medical insurance. Approximately 40 percent are uninsured; another 37.3 percent are on Medicaid. In contrast, only 17 percent of service area residents are either uninsured or on Medicaid.

Health *Status*

Lack of prenatal care, teenage pregnancy, and maternal substance abuse are all problems in WYHC's target market. As compared to the U.S. Public Health Service's objective that 90 percent of all pregnant females should obtain prenatal care within the first trimester of pregnancy, in WYHC's service only 71.8 percent received this care. Although the incidence of teen pregnancy in Albany county is only slightly higher than the average in upstate New York, as with all the other prenatal care indicators within the Center's service area, this incidence is higher. Approximately 7.6 percent of births were to mothers under the

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6 **Population data is taken form the Program Description of the Whitney M. Young Section** 330 **funding application.**

age of 18 compared to 3.0 percent in upstate New York. Nearly 14 percent of African-American infants born in the service area were mothers under the age of 18.

The Center's target market includes a significant number of substance abusers. Estimates suggest that 0.8 percent of the community population are substance abusers; WYHC reports a 1.8 percent incidence of substance abuse among its users. In the WYHC service area, 0.2 percent of citizens are reported to be HIV+. Center statistics show that 1.6 percent of clients have tested positive for HIV.

Other health status indicators of. concern in the Center's service area are the reported high incidences of lead poisoning, Hepatitis B and tuberculosis, and sexually transmittable diseases.

Primary *Health Care* Delivery System

While supporting documentation is unavailable, anecdotal evidence suggests that although the Albany County area as a whole has sufficient physicians to serve primary care needs, a shortage of primary care physicians exists for Albany's medically indigent. One local health official noted that there was only one obstetrician in the entire city who accepts Medicaid clients. In the absence of support by a base of private practicing physicians, the indigent rely mainly on three institutional programs including, the primary care programs and/or emergency room services of Whitney M. Young Health Center, Albany County Department of Health, and St. Peter's Hospital Family Health Center. Each of these facilities offers comprehensive primary care services for which patients are eligible regardless of their ability to pay. Brief but more detailed descriptions of other participating primary care organizations and agencies are provided in the next chapter.

Summary

In summary, WYHC's community includes problems endemic to inner-city urban areas including unfavorable socio-economics and the concomitant problems of substance abuse, perinatal problems, etc. that manifest themselves in poor community health status indicators. The following includes a table that summarizes and compares seiected factors for both WYHC's service area and its users.

SERVICE AREA AND USER CHARACTERISTICS OF THE WHITNEY M. YOUNG HEALTH CENTER[7]

	SERVICE AREA [PERCENT]	USERS [PERCENT]
Race/Ethnicity		
White [Non-Hispanic]	77.0	43.5
Black/African-American [Non-Hispanic]	16.5	46.4
Hispanic/Latino [of any race]	5.7	4.3
Other	0.8	5.8
Income		
Under Poverty Level	9.7	74.1
101-I 50% Poverty	18.4	21 .o
151-200% Poverty	71.9	4.9
Insurance Status		
Medicaid	10.0	37.3
Medicare	33.7	8.7
Other	49.2	13.7
None	7.1	40.3
Special Population		
Substance Abusers	0.8	1.8
HIV	0.2	1.6
Homeless	2.7	2.0

7 This chart has been adapted from the 1990 Whitney M. Young Section 330 Continuing Funding Application

CHAPTER II: DESCRIPTION OF LEAD AND OTHER AGENCIES/ORGANIZATIONS THAT PARTICIPATE IN PRIMARY CARE COORDINATION EFFORTS

2.1 Whitney M. Young Health Center

Since its founding, the Whitney M. Young Health Center has developed into a comprehensive primary health care clinic. Located in Albany's predominantly low-income Northside, the Center addresses the various health care needs of the medically indigent community. The WYHC opened under the direction of Albany Medical College in 1971 to respond to the community needs for quality health care in the predominantly low income area of Albany's Northside. The initial services offered by the Center included medical care, dental care, transportation, and nutritional, laboratory, mental health, and social services. The Center expanded its client base steadily throughout the 1970s. In 1974 it moved from its original temporary facility into its current location on Lark and Arbor Drives.

Special program grants drove service expansion during the 1980s, and in 1987 ownership was transferred from the Albany Medical College to the Health Center Board. At the time of the transfer of ownership, financial difficulties and low morale plagued the Center. With the aid of a New York state financial package and strong leadership from new Executive Director Evelyn Williams, WYHC reorganized its operations and emerged from its difficulties. By 1990 the service network included 14,500 active medical and dental users. Today, the Health Center is a full-service, comprehensive ambulatory care center. In addition to general primary care services, the Center has developed many substance abuse and sexually transmitted disease programs. Services provided by the Center include: medical care, dental care, support services, and specific grant funded services. Medical care services include: routine medical care, preventive medicine, physical examinations, obstetrical/gynecological care and family planning, mental health, immunizations, nutritional, 'eye examinations, dermatology, podiatry, AIDS education and counseling, and screening for and diagnosis of long term conditions. Dental services include: full mouth x-rays, prophylaxis cleaning, fluoride treatment, dental health education, fillings, extractions, partial and full dentures, limited crown, bridge, and root canal work, and emergency treatment.

In addition to offering medical and dental care treatment facilities, the Center supports these practices with a number of services, including a pharmacy, routine clinical laboratory, x-ray facilities, social outreach services, family counseling, and 'Healthy Weight,' a group weight reduction program.

Among the most widely used and successful services at the Center are the special programs, some of which are detailed later in this report under the description of coordinated primary care programs. These include the Family Alcoholism and Chemical Dependency Treatment Services Program (FACTS), the Children of Trauma Group, the Methadone Maintenance Treatment Program (MMTP), the Perinatal program, the Women, Infants, and Children (WIC) program, and Project T.E.A.C.H. The FACTS program provides diagnostic

evaluation, therapeutic services , and case management to treat alcohol and drug dependent patients. The MMTP is an outpatient drug treatment program that provides counseling and medical service to patients with narcotics additions. The comprehensive perinatal program provides medical services and educational programs related to pregnancy and parenting. Project T.E.A.C.H. (Treatment Education Assessment Counseling Health) is an HIV/AIDS awareness program for the community.

Total and patient grant revenue to the center in 1991 approximated $6.7 million as indicated in the table below. The single largest source of revenue is from Medicaid ($3.6 million) and the second largest revenue source is Section 330 ($1.6 million). WYHC's two main grants T.E.A.C.H. and MMTP (discussed later in this report) were responsible over $300,000 in 1991.

1991 REVENUE - WYHC		
Patient Revenue		
MEDICARE	$ 103,972	
MEDICAID	3,609,655	
SELF-PAYING	649,344	
OTHER	174,483	
Total Patient Revenue		**$ 4,537,454**
Section 330 Grant		**1,644,226**
Other Grants		
WIC	$ 152,054	
TEACH	151,284	
MMTP	179,868	
Other	53,401	
Total Grants		**$ 536,607**
Total Revenue - 1991		**$ 6,718,287**

Administrative responsibility for the Health Center has been vested by the Board of Directors to the Executive Director. The director is responsible for short-term and long-term planning and for the programmatic initiatives of the center. Four departments report to the Executive Director. These include operations, fiscal operations, medical, and dental, each of which is headed by its own director. While formal reporting relationships exist, the Executive Director maintains an open-door policy. This does not imply circumvention of the chain of command; however, the director wants to remain connected to all personnel. The organizational chart which appears on the next page illustrates formal reporting relationships.

2.2 Other Participating Agencies/Organizations

A host of organizations and agencies participate in primary care coordination efforts with the WYHC.

Albany County Department of Health

The Albany County Department of Health (ACDOH) is the official public health agency serving the Albany county region. The city of Albany does not have a health department. ACDOH provides primary care services to the city's Southside; WYHC's primary service area is the city's Northside. The ACDOH role is mainly that of a health care service provider, although it also has administrative and data collection responsibilities. The health department operates a comprehensive medical clinic at the department's main office in the city's Southside. Satellite clinics are operated in Ravena and Cahoes. These clinics offer a sliding fee scale, accept Medicaid patients, and do not deny service because of a patient's inability to pay. Like the WYHC, the Department targets the medically indigent community and recognizes especially the needs for child and prenatal health. In addition to the in-house clinics, the ACDOH provides home health care services, health education outreach programs, immunizations, and lead poisoning prevention screening. As will be discussed later, a number of ACDOH programs are coordinated with the Whitney M. Young Health Center.

St. peter's Hospital

St. Peter's is a voluntary general medical and surgical hospital with approximately 400 inpatient beds. While St. Peter's operates an emergency room and general outpatient clinics, its primary role in coordination efforts is to provide inpatient care through its inpatient alcohol and substance abuse unit "SPARC" (St. Peter's Addiction Recovery Center) in addition to providing general inpatient acute care services.

Albany Medical Center

Albany Medical Center is a 400+ voluntary, teaching hospital that provides secondary and tertiary care services. It offers outpatient services and general acute care in addition to inpatient psychiatric care.

New York State Department of Health

While the State Department of Health plays a very limited role in direct services, its major role is in providing funding for a myriad of coordinated care efforts.

Arbor Hill Elementary School

The elementary school, which is located across the street from WYHC, is involved in numerous coordinated primary care projects. It offers pre-kindergarten through sixth grade to approximately 800 (check this) students. WYHC views the school as an integral component of its target population and the health of the community at large.

St. Joseph's Housing Coalition (SJHC)

SJHC is a not-for profit organization that has a history of successful funding and subsequent development of approximately 150 housing units for special needs populations such as substance abusers, the homeless, and other medically underserved populations. SJHC provides the shelter and relies on WYHC to provide the needed services.

Albany County Department of Social Services

The primary role of the department of Social Services is to determine eligibility for and enroll community residents in various social service programs.

St. John's Project Life

St. John's Project Life is a "half-way" house that provides living arrangements for 24 men; St. John's coordinates with WYHC for many social and medical support services.

Salvation Army

The Salvation Army has a long history of coordinating programs with WYHC for the many individuals, often prior substance abusers that enter the Salvation Army's numerous rehabilitation programs.

SUNY *at Albany, School of Public Health*

The School of Public Health is a relatively new program that is still seeking accreditation. As accrediting agencies are increasingly requiring community internships for students, the School of Public Health has looked to WYHC as a site for practical rotations for its students.

Albany County's Criminal Justice System

The criminal justice system looks to WYHC for medical screening as well as a primary care site to which to refer offenders with substance and alcohol abuse problems.

CHAPTER III: COORDINATION EFFORTS

Many of the coordination projects began in the last few years or have expanded as WYHC's leadership and funding services have stabilized. In this chapter we present an overview of the primary care coordination efforts, including overarching factors that generally characterize all coordination efforts. In addition we discuss information on individual efforts including their objectives, primary services and activities, participating agencies, and funding resources.

3.1 Factors that Characterize WYHC's Primary Care Coordination Efforts

For this, the first of the six case studies that will be conducted as part of the primary care coordination study, we found the following characteristics to typify WYHC's primary care coordination efforts. We provide these characteristics to provide an overview for the more detailed descriptions of individual programs that follow:

- **Coordination projects responded to unmet/underserved community needs.** All of the projects identified below were organized in response to existing medical and social needs within the community. Coordinated efforts were viewed as a way to combine limited resources to meet those needs that otherwise might not be met.

  Projects were coordinated to provide a continuum of care. In general participating agencies sought to coordinate services to ensure that the "whole patient and whole community" were treated with the understanding that a failure or lack of services in one part of the continuum would result in an unnecessary burden on another part of the continuum.

  Coordinated efforts were initiated as a result of informal contacts and historical working relationships. In general, the coordination efforts detailed below were conceived as staff met informally over lunch and spontaneously identified unmet needs and ways to address them collaboratively.

  Projects were characterized by informal agreements. For the following projects with only one exception, no formal affiliation or governance arrangements exist. Funding was obtained and maintained by the individual agencies for the discreet services each agency provided. For instance for the housing services for substance abusers, St. Joseph's Housing Authority obtained funding for bricks and mortar through its funding streams and WYHC funded the services component through its funding sources. Participating agencies often had a history of informal collaborative arrangements.

- **Participating agencies serve essentially the same communities.** With the exception of the State of New York Department of Health that serves the entire state, the participating agencies serve the same community and target populations.

- **Each agency often provides a unique component of care.** The collaborative agreements were often characterized by participating agencies providing unique components of care. For instance, in the F.A.C.T.S. program described below, WYHC provides the outpatient component of care and St. Peter's Hospital, the inpatient component.

No **formal evaluation measures exist for the coordination efforts.** When interviewees were queried about formal evaluation measures for coordination programs, e.g. resultant decreases in mortality and morbidity statistics, these more formal measures did not exist. However, interviewees related that less formal measures such as an increase in the number of patients served by these programs were reflective of their success.

In general, we expect that the general characteristics of WYHC's primary care programs as outlined above, may not typify those of other organizations. For instance, in Chicago, the second of the six site visits, we expect the more complex environment to drive more formal primary care arrangements.

3.2 Principal Primary Care Coordination Efforts

in this section we will discuss six of the Whitney M. Young Health Center's coordinated care projects, These projects illustrate many of the best practices of the Center and therefore may provide models for programs elsewhere.

Project T. E.A. C. H.

Project T.E.A.C.H. (Treatment Education Assessment Counseling Health) became operational in 1991. It is aimed at reducing the spread of the HIV virus and promoting comprehensive care for HIV+ patients. The Health Center provides primary health services, including case management, comprehensive medical, dental, and nutritional services, and HIV testing. In addition, the Center offers transmission and prevention education seminars and operates counseling and support groups for HIV+ patients, and their families. The Albany Medical Center supplements WYHC medical treatment by providing secondary and tertiary care to HIV+ patients. Community-based organizations, most notably the Salvation Army, promote the program to their constituents and serve as a point of entry to the system via referral to Project T.E.A.C.H. Whitney Young also integrate its HIV services with educators from the Health Systems Agency of Northeast New York, who act as the leader of the upstate New York AIDS consortium. T.E.A.C.H provides case management services that include referrals to other agencies and organizations for financial, housing, and legal services.

Funding for the services detailed above is contributed by the HRSA Ryan White Title III grant and by the New York State Department of Health. WYHC has received additional funding to create a Day Activity Center for AIDS patients.

ACCESS/OSAP Grant

Initially an effort to secure a grant from the Office of Substance Abuse Prevention (OSAP), the ACCESS program has developed into a loose federation addressing issues of substance abuse and perinatal addiction in the Albany area. The Whitney M. Young Health Center, St. Peter's Hospital's Family Health Clinic, and Albany County of Health originally submitted an application to OSAP to provide funding to support the placement of an addictions specialist in each of the three clinics, Since uniting to submit the grant, the organizations have improved referral relationships related to perinatal services and begun a training program in which WYHC counselors, who are experienced in a multi-cultural environment, work with St. Peter's providers on issues of cultural sensitivity. Each of the three providers offer substance abuse counseling and treatment and maternal health services. WYHC also brings to its perinatal services its Methadone Maintenance Treatment Program and outpatient medical services, St. Peter's Hospital the inpatient Addictions Recovery Center (SPARC). It is hoped that the grant will be approved soon to facilitate service coordination through the use of the addictions specialists. Whether or not ultimately funded, like many collaborative grant application efforts, the effort itself has facilitated pre-existing referral relationships.

CHAMP Day

CHAMP Day is a health fair coordinated by WYHC, that includes participation by other area health care providers, elementary schools, and social service agencies. CHAMP Day features booths which are both enjoyable and educational for students and their families. Participating agencies are not allowed to just hand out materials; they are required to develop some type of interactive game or other form of entertainment. The purpose of this program is to promote the 'wellness' image of WYHC and to disseminate information to the community about the services offered at participating organizations. Each organization funds its own participation and community donations are solicited. CHAMP Day forms the basis of health care relations with the public school system and has facilitated discussions for coordinated program development with the local high school for the development of programs.

F.A.C.T.S.

F.A.C.T.S., Family Alcoholism & Chemical Treatment Services, is a coordinated program which works to achieve patient sobriety through a holistic approach to alcoholism as a complex illness whose causes and effects appear in multiple aspects of an individual's life. This approach employs the following services to address alcoholism: individual and group counseling and alcohol rehabilitation services, psychological diagnosis, alcoholeducation,

nutrition information, socialization programs, and case management services to oversee the progress of an individual throughout the program.

Many agencies offer their individual expertise in support of the program. Health services are contributed by a number of providers: the Whitney M. Young Health Center provides primary counseling and health services; St. Peter's Addictions Recovery Center is used for inpatient services, especially for perinatal addiction; Albany County Substance Abuse Clinics provide comprehensive mental health and mental retardation evaluations. Other agencies contribute through human service programs: St. Joseph's Housing Coalition offers its independent living facilities for recovering alcoholics; St. John's Project Life is a 24 bed male halfway house and 20 bed therapeutic community; the Arbor Hill Alcoholism Program facilitates its services as part of the patient's re-entry to socialization; and the Albany County Department of Health plays a strong educational role, elaborating especially on HIV awareness for drug addicts, The Foster Grandparent Program provides free nursery services to the Programs day treatment patients.

The funding for F.A.C.T.S. comes from the New York State Division of Alcohol and Alcohol Abuse and the Albany County Department of Mental Health.

Intra-Center Primary Care/Substance *Abuse Program*

The Intra-Center Primary Care/Substance Abuse Program operates internally to the Health Center and may well be considered as a model for inter-agency linkage programs. This program involves the identification and intervention on the behalf of patients with mild to severe drug and alcohol problems. Providers in WYHC are trained by Center staff and New York State Department of Health professionals to recognize symptoms of substance abuse and instructed on the registration of substance abusing clients in appropriate treatment programs. In some instances, WYHC staff escorts patients identified as substance abusers from the primary care building into an adjacent building for substance abuse treatment and counseling.

Currently, the program is funded by a HRSA Primary Care/Substance Abuse grant and by the New York State Department of Health. The Community Drug Assessment and Treatment Systems (C-DATS) program, 'presently being developed by the State Department of Health is expected to fund WYHC as the first of two sites to be operative under that funding.

Methadone Maintenance Treatment Program

The Methadone Maintenance Treatment Program (MMTP) is the only area program that dispenses methadone in the outpatient treatment of heroin-addicted patients. Like the F.A.C.T.S. program, MMTP considers the social, medical, and health needs of the patient and provides services to address the multitude of problems faced by the recovering addict. These services include: comprehensive medical and health care services, case management and individual treatment program design, individual and group counseling, social support services, AIDS prevention and transmission education, and vocational assistance. Poly-

addicted patients are not treated in the MMTP program but are referred to appropriate programs which can address their multiple addictions.

The Whitney M. Young Health Center provides off-site treatment, counselling, referrals, and on-site health care. The Albany County Department of Health contributes AIDS education and tuberculosis and HIV screening. Specific substance abuse service providers are called upon for inpatient services, including Crouse-Irving and St. Agnes Hospitals. Agencies such as the Albany county Department of Social Services offer varied social support services.

The treatment program is funded by the New York State Department of Health and the New York State Department of Substance Abuse Services.

Public *Health* Training

More recently WYHC has worked with SUNY's Public Health School, to coordinate training opportunities for its public health students. Community training sites are increasingly important components of public health training programs. WYHC/s full-time Medical Director has a Masters in Public Health in addition to his M.D. and came to WYHC in part because of collaborative opportunities.

CHAPTER IV: LESSONS LEARNED BEST PRACTICES OF COORDINATION EFFORT

In this chapter, we describe the lessons learned/best practices elucidated from this first site visit. We will continue to refine this list in subsequent site visits for inclusion in the final report. We have organized the findings into factors that promoted collaboration at WYHC including: macro-environmental (e.g. national or state-wide factors) and local issues, and interpersonal and operational factors.

4.1 Macro-environmental Factors

The Availability of Resources or the Potential for Resources

The existence of resources increased the desirability and probable effectiveness of program coordination; coordination was also promoted by the absence of resources which spurred the need to unite to pool limited resources. Financial resources from the state, federal government and foundations were the primary resources driving program coordination, When the potential for funding existed, organizations were more likely to coordinate services to obtain it. As demand for federal and state funding is increasing and the total dollars available are decreasing, participating agencies related that distinguishing themselves as providers of a complex range of coordinated services increased their likelihood of obtaining funding. These funding resources diminished, coordination efforts were facilitated by collaborative efforts to maximize dwindling resources.

National or *State Initiatives*

Collaboration was promoted by initiatives at the state and national level. Interviewees at WYHC cited three primary examples of factors at the national or state level that promoted the development of coordinated primary care efforts. The first example was New York State's progressive policies with regard to funding supportive housing and national initiatives. These policies facilitated the WYHC's development of many coordinated housing and supportive service initiatives. The second was the increasing emphasis at the national level on on-site training for public health school graduates. This emphasis spurred collaboration between the local school of public health and WYHC to develop on-site rotations for graduates. And finally, coordinated efforts enabled participating agencies to pool their resources to meet and keep abreast of state regulatory requirements.

4.2 Local Environmental Factors

Response to Demonstrated Community Needs

A critical success factor for coordinated efforts was that they responded to demonstrated community needs — needs that were often too substantial or too complex to be handled by any one organization. In WYHC's community the demand for primary care services has **grown** in part due to increases in substance abuse and HIV populations. Collaborative efforts have been successful in part because they are needs driven; they were developed to fill existing service gaps.

Recognition ***that*** *Complex Service Demands* **May** *Require Combined Expertise*

Successful coordination projects were promoted by a view that the whole was greater than the sum of its parts. While on-site, many interviewee provided examples of projects that were unsuccessful because participating agencies placed their interests ahead of the broader needs that the coordination effort was attempting to fill. Specific examples were given of coordination efforts that did not develop due to turf battles. In contrast, where inter-agency collaboration was viewed as a way to enhance one's own services projects were much likely to be successful.

The *Achievement of Greater Continuity of* ***Services***

WYHC attributed the success of some projects to the fact that these projects promoted integration of care across the continuum — projects were viewed as a way to treat the "whole patient and whole community." The ability to integrate care across a continuum of services was a critical component of many of the primary care coordination projects. Agencies were eager to participate in projects that helped ensure that their clients would not experience major service gaps. Many of these networks consisted of informal referral relationships. For instance, WYHC's outpatient substance abuse program and St. Peter's inpatient substance abuse unit leveraged their relationships to submit collaborative grants that were more likely to be funded because of the continuity of services they provided.

Location

Proximity to other agencies and organizations promoted collaboration. Many interviewees related that location was a key factor in successful primary care coordination projects. Close proximity created overlaps in target populations and facilitated communication and in formal networking and making it easier to identify opportunities where collaboration could enhance services. For example, staff at WYHC targeted programs to raise health awareness and self-esteem among the community's children at an elementary school just across the street. The elementary school is currently working with WYHC and a variety of other agencies to develop a "community school" that will be open seven days a week and provide a comprehensive range of educational and social programs.

The *Ability* to *Generate* a Critical Mass *of* Patients

WYHC's primary care coordination projects were successful in part because they were supported by a critical mass of patients. More patients meant more resources to develop a broader range of services. The ability to get funding, recruit staff, etc. was in part based on the availability of a critical mass of patients that the coordinating agencies provided. For many of the projects, generating a sufficient patient base to support program development required the inter-agency referrals that were often times facilitated by collaborative efforts.

4.3 Interpersonal Factors

Strong Leadership

When asked -what factors were critical to the development and success of primary care coordination projects -the most frequent answer was the presence of a strong leader. Interviewees from the Whitney Young Health Center, and other participating agencies most frequently cited the presence of a strong leader as critical to developing successful primary care coordination projects. Strong leadership was characterized by:

- **The ability to cultivate a culture that promotes interest in identifying new ways of getting things done.** Interviewees related that WYHC's current leader encourages people to generate ideas and follow-through on them. Staff related a sense of empowerment and heightened creativity that was not associated with an "I told you so" for those efforts that proved less successful. Health department collaboration was reported to be facilitated by its strong current leadership that encouraged people to try new ways of getting things done.

- **Credibility with external as well as internal constituents.** Participating agencies related their confidence in WYHC's leadership was a major reason agencies pursued coordination projects with WYHC. Confidence came from the participating agencies' beliefs that leadership: was generally capable, had successfully completed a number of prior coordination projects, was straightforward and honest, and had the community's best interests at heart.

Communication

Coordination project success was often related to strong communication networks, not just between leaders of the respective coordinating organizations but between the rank and file as well. Communication networks were often characterized as informal. Interviewees cited many examples of new collaborative efforts that were initiated as a result of informal meetings — and Food. **These informal meetings typically included persons interrelated programmatically and professionally, e.g. nurses meeting with nurses and social**

workers with social workers, etc. Interviewees repeatedly underlined the importance of informal meetings in identifying and promoting opportunities, and examples where more formal top-down efforts were less successful either because they were not viewed as an us/us strategy or because they were not necessarily responding to true needs as identified by the rank and file.

4.4 Operational Factors

Quick *Decision* Making/Quick Successes

Interviewees related that coordinated program development was promoted by quick decision making and quick successes. Where potential participants perceived that decision making was excessively delayed by bureaucratic layers or indecisiveness, participants were less likely to be enthusiastic about potential initiatives, Quick decision making and successes, on the other hand, were likely to promote collaboration. A prior history of successful initiatives was important in establishing credibility with a host of important potential participants including new agency leaders, potential grantees, and even prior collaborators, etc. For example, a WYHC staff member presented his idea to develop a self-esteem program at the elementary school. The program was'underway within days.

Participants Perceive Real Benefits from Collaboration and *are Invested in the Process*

Where participants perceived real benefits from collaboration, they were more likely to be invested in program development. Benefits included many of the aforementioned issues included a sense that programs responded to real community need, filled existing service gaps, and increased continuity of care.

Pre-existing Referral Networks

Pre-existing referral networks were related to be critical to the development of many of the primary care coordination projects. For instance, the Salvation Army historically referred many of its clientele to WYHC's outpatient substance abuse programs. When WYHC obtained funding to expand HIV services, WYHC targeted the Salvation Army (in addition to other organizations), for new HIV community outreach programs. Many interviewees related that the importance of pre-existing networks in generating new coordination efforts, Many examples were provided of projects that were initiated almost serendipitously as providers from different agencies met to share a cup of coffee. Interviewees related that these informal networks were much more likely to yield new projects and new meetings than more formalized encounters.

Previous Funding Contacts

A fundamental factor supporting the development and ultimate success of the coordination projects was the ability to generate stable funding sources. Access to funding and strong historical relationships were cited by many interviewees as a major factor accounting for the success of coordination projects. Many of the projects were funded through multiple sources. Reliance on multiple funding sources served to increase funding overall and provided greater stability should any one funding source dry up. Funding was generally sent directly to participating agencies for specific functions and not accounted for in centralized budget, For example, for coordination between the county health department's case manager and the WYHC TEACH program occurred without any transfer of funds or common financing. The TEACH budget was autonomous to WYHC and the case manager independently financed through the county's budget.

The Ability to Leverage Limited Staffing Resources

Limited staffing often led to the development of coordinated programs. As demand for services has increased and resources to develop those services more constrained, WHYC has increasingly used coordinating services as a way to maximize limited staffing resources. For instance, as WYHC developed its substance abuse programs it relied in part on case managers from the Department of Health to help coordinate those services. WYHC collaborated with other agencies in staff cross-training programs. In most instances, shared staffing arrangements were informal and not based on written agreements, shared salaried arrangements, etc.

Interrelatedness of Governing Boards

For the WYHC, the Board itself was not a major factor in the development of coordination effort except to the extent that the Board approved projects that were initiated. However, the issue of the Board interrelatedness did serve to promote coordinated program development in one case. The Director of WYHC's F.A.C.T.S. program was a member of the Board of the St. Joseph Housing Authority. Interviewees related that in part was a factor facilitating the development of coordinated housing and service programs between the two agencies.

Summary

In summary, a host of factors promoted primary care coordination projects at WYHC. This list of factors will be refined during subsequent site visits. In addition, the implications of these findings both for other community health centers and grantees such as HRSA will be elucidated in the final report. For example, to the extent that other HRSA funded projects serve similar or different communities, how generalizable are the findings? What elements might leaders of other programs employ to promote/generate successful coordination efforts? What do the findings suggest for future HRSA funding policies? Other initiatives at the federal and state level? These types of questions will be explored in the final report.

APPENDIX E:

HRSA PRIMARY CARE COORDINATION CASE STUDY SITE REPORT

PRIMARY HEALTH CARE CONSORTIUM OF DADE COUNTY MIAMI, FLORIDA

92LF0883

TABLE OF CONTENTS

CHAPTER I: INTRODUCTION

This, the sixth and final report in the series of case studies, examines the coordinated primary care projects of the Primary Health Care Consortium of Dade County (PHCCDC) in Florida, The Consortium was officially incorporated in 1986 following the development in 1985 of Miami's Urban Strategy Plan, a combined effort of local Community Health Centers, the Dade County Health Department, Jackson Memorial Hospital and the Public Health Trust, and other members of the Dade County health care community. The consortium was developed to enhance the system of primary care services available to the county's medically indigent by providing a forum for key primary health care providers. Community health centers are the consortium's basic focus because the consortium was initially formed by CHC members; however, because of the participation of other non-CHC health providers (hospital and health department, for example) the consortium addresses CHC issues in the broader context of Miami's health care delivery system. As the Consortium has continued to grow, it has added the Dade County Area Health Education Center (AHEC), numerous private and public health clinics and other local health organizations to its membership, which currently encompasses all of the major components of Dade County's primary care delivery system.

The members of the Consortium receive Health Resources and Services Administration (HRSA) funding through a variety of sources. The Community Health Centers are recipients of Section 329 and 330 Public Health Service Grants. Some consortium members are also participants in the South Florida AIDS Network, which receives Ryan White funding. A major source of funding for the Consortium's primary care clinics comes from the state's Health Care Access funding.

To help develop the context for PHCCDC's coordinated primary care programs, in Chapter I we provide an overview of the Dade County community. The Primary Health Care Consortium of Dade County and the organizations with which it collaborates are discussed in Chapter II. A general description of their coordination efforts follows in Chapter Ill. Chapter IV summarizes the lessons learned and best practices elucidated during the case study.

The Community

Dade County is located along the southern tip of Florida, the closest American port to the countries of the Caribbean. The County is divided into municipalities'. The proximity of Dade County to Latin America has led to its rapid expansion to accommodate influxes of immigrants, most notably from Cuba and, recently, from Haiti as well as other Caribbean and

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[a] Dade County consists of the following municipalities: Bal Harbour, Bay Harbor, Biscayne Park, Coral Gables, El Portal, Florida City, Golden Beach, Hialeah, Hialeah Garden, Homestead, Indian Creek, Islandia, Key Biscayne, Medley, Miami, Miami Beach, Miami Springs, North Bay Village, North Miami Beach, Opa-Locka, South Miami, Surfside, Sweetwater, Virginia Gardens, and West Miami. Some areas of Dade County are not incorporated as individual municipalities.

Central American countries. Many of these immigrants have established ethnic communities throughout the Dade County area. While the northern and eastern municipalities of Dade County are primarily urban, the county's more southern areas are more agricultural. As a result, a substantial number of migrant and seasonal farmworkers reside in the county.

Demographics of Community and Consortium Users

Throughout the 1980s Dade County experienced population growth of between one and two percent annually. Although this rate of population expansion is less than that experienced by other Florida counties, it amounts to a 300,000-person increase between 1980 and 1990. The Metro-Dade County Planning Department reports a 1991 Dade County population of 1.97 million. The largest of the municipalities are Miami (360,000), Hialeah (188,000) and Miami Beach (93,000). Unincorporated areas of Dade County house approximately 1 million persons, more than half of the county's population.

Dade County is home to a significant number of African-Americans and Hispanics. Some 20 percent of residents are African-American; nearly 50 percent of are Hispanic (although "Hispanic" includes a wide range of ethnicities). The central corridor including, from east to west, Surfside, Miami, Hialeah, Hialeah Gardens, and West Miami contains the highest fraction of Hispanic residents, ranging from 62 percent to 93 percent of the total population. The populations of Dade County's north, central and southern municipalities contain the greatest number and fraction of African-American residents, In particular, 69 percent of northern Opa-Locka municipality are African-American. Nearby Miami, North Miami, North Miami Beach, El Portal, and Florida City, also contain a higher fraction of African-American residents than the county average. Homestead and South Miami, in the southern portion of the county, have similarly high representations of African-American residents.

Exceeding their representation in the population as a whole, Hispanics represent a large proportion of the population served by PHCCDC clinics. Individual clinics provide healthcare to specific nationalities within the Hispanic population. (See Section 2.2) A high fraction of PHCCDC users live in poverty, and few have health insurance. According to the Borinquen 1992 - 1993 Section 330 Continued Funding Application, for example, 98 percent of its users live below the poverty level and only 25 percent have Medicaid, Medicare, or private insurance coverage.

Local ***Economy***

The most striking feature of the Dade County economy is its diversity. The port of Miami facilitates international trade; the county's southern, coastal climate inspires tourism; In general, the economy of greater Miami is service based. Services such as banking, finance, tourism, retail trade, and international commerce supply more than half the region's revenue and jobs. The manufacturing sector, a distant second, is supported especially by hi-tech medical product and apparel manufacturers. In the Homestead area of southern Dade County agriculture is a major industry. Due to its prolific production of tomatoes, carrots, etc., the county is known as the winter vegetable basket. While the agricultural sector is not a large employer, it does generate significant revenue for the county.

The official unemployment rate hovers around 8.5 percent in Dade County, although the Chamber of Commerce contends that this figure underestimates the true number of out-of-work persons by 2 percent. The Chamber reports that employment is beginning to improve in recent months. Improvement in Latin American economies have fueled an increase in international trade, which contributes to job expansion.

Health Status and Special Health Needs

Examination of Dade County's health status indicators and interviews with local health officials reveal area needs similar to those in most urban centers and influenced by the county's proximity to Latin America. Anecdotal evidence suggests that lack of prenatal and child care, substance abuse, and AIDS are the county's most pressing health problems. HIV+ patients, who, although they comprise a minimal fraction of primary health clinic patients, require multiple services. In 1990 Dade County experienced a low birthweight rate of 7.92 per 100 and infant mortality rate of 10.5 per 1,000, both which exceed the national average of 6.41 low weight births and 10.2 infant deaths.

The constant influx of immigrants from Latin America complicates the health care needs of the county. Many immigrants are plagued by preventable medical conditions, such as tuberculosis, which could have been avoided with early detectlon or consistent primary care. Other populations which require special services are migrant and seasonal farmworkers, whose mobile lifestyles do not lend themselves to routine primary care and follow-through.

Primary Health Care Delivery System

Three major groups provide primary health care to the medically indigent in Dade County community; all of them are members of the Consortium. These include the community health centers, the Dade County Department of Public Health, and the Public Health Trust. Each of these groups is described in more detail in the next chapter. The community health centers include five federally funded CHCs and one independent CHC. CHCs among them have 10 sites that serve the entire county region from its most northern to its most southern points. The Department of Public Health staffs two comprehensive primary care clinics and numerous other clinics with categorical services. The Public Health Trust, the Dade County-supported agency responsible for indigent care, manages two county primary care clinics (one recently transferred from county management). Jackson Memorial Hospital, also operated by the Trust, is the only public hospital in Dade County; it provides ambulatory and emergency care to the indigent as well as inpatient acute care. In addition to these three groups, several small non-federally funded primary care clinics called "Quintas" serve indigent Cuban-Americans.

Summary

The overarching influences on Dade County are its geography and climate. The county's proximity to Latin America influences its demographic composition, health needs,

and health system design. In general, the diverse Dade County community includes problems endemic to both inner-city urban areas, such as unfavorable socio-economics and concomitant health problems, and problems which are more typical of agricultural environments, such as the health problems of migrant agricultural workers.

CHAPTER II: DESCRIPTION OF LEAD AND OTHER AGENCIES/ORGANIZATIONS THAT PARTICIPATE IN PRIMARY CARE COORDINATION EFFORTS

2.1 Primary Health Care Consortium of Dade County (PHCCDC)

The Primary Health Care Consortium of Dade County is an integrated system of primary care service delivery which served the ethnically diverse medically indigent population of Dade County, Florida. All of the major participants in the region's primary care system are represented as full members in the Consortium. The core group of members includes the area's five community health center, each of which, by virtue of its geographic location, serves a unique population, distinct in ethnicity, but similar in health concerns; Dade County Public Health Department, and the Public Health Trust.

The Consortium was officially organized in its current form in 1985 to develop an urban strategy plan for Miami. Participants in this plan's creation included the community health centers, the public health department, and the Public Health Trust. Submitted to HRSA's Deputy Director, the urban strategy plan identified area health concerns and outlined step-wise, coordinated action plans to address those issues. HRSA had instructed the group to frame such a plan as a requisite to secure the placement of National Health Service Corps physicians in their clinics as well as to provide funding support to actualize the urban strategy plan.

The Consortium was not the first attempt of Dade County health administrators to unify or coordinate primary care services. Some degree of coordination had existed for over five years, although those programs were mainly project-specific and coordinated directly between two organizations. Previous efforts at large-scale coordination had not been successful because the desire for individual autonomy exceeded the anticipated benefits of collaboration. In its current form, the Consortium is flourishing because it preserves organizational autonomy while encouraging service linkages and resource sharing. Community health centers, for example, file applications for and receive awards of federal grants separately, yet share physician and nurse services as appropriate among themselves and with the Public Health Trust and the Department of Public Health.

Another factor contributing to the previous limited success of coordination projects was the perception that the CHCs provided low-quality health care. This was fueled by the characterization of CHC physicians as poorly trained or formerly retired practitioners. The National Health Service Corps doctors and increased clinical standards at the CHCs helped eradicate this opinion.

The Consortium has recently named Betsey Cooke as Executive Director. Ms. Cooke is the first administrator of the Consortium since 1990, when the position was vacated as funding support was lost. The Consortium had continued to operate without an official director, holding regular Board of Directors meetings and functioning as a collective decision making body. While the consortium made progress in a number of areas during that period, members acknowledged that the absence of an Executive Director limited progress somewhat.

Attached below is a table summarizing the 1990 revenue of the Consortium's primary care centers. (The budget of the AHEC, Public Health Trust, and department of public health are not included.) The subtotal for the centers exceeds $34 million, Supplying more than $14 million individually to the five community health centers, the federal government is the largest single financier of the Consortium's activities, Totalling nearly $8.4 million, patient revenues, especially Medicaid payments, account for a substantial portion of the consortium's budget. While the state government officially provides $1.7 million to the Consortium, this figure is misleadingly low. In fact, a substantial portion of the $8.2 million revenue attributed to the local Dade County government and its incorporated municipalities, is actually conferred by the state to the county, who acts as executor of Florida's Health Access grant, allocated by the state to health departments for primary care services.

ACTUAL 1990 REVENUE - PHCCDC		
Patient Revenue		
Medicare	$ 532,267	
Medicaid	4,669,422	
Insurance	576,271	
Self-Pay	2,602,730	
Total Patient Revenue		**8,380,690**
Federal Government Grants		**14,170,607**
State Government Grants,		**1,726,716**
Local Government Grants		**8,232,226**
Total Other Income		**1,708,841**
Total Projected Revenue - 1990		**$ 34,219,080**

The Consortium consists of organizational, associate, individual provider members. Memberships fees are $1000 for organizational members, $500 for associate members, and $25 for individual providers. All of the federally funded CHCs belong to the Consortium, but they each file individual applications for Public Health Service grants and maintain autonomous organizational structures. 3rganizailonal members include the following, the first five of which are Section 330-funded CHCs:

- Borinquen Health Center.
- Coconut Grove Family Health Center.
- Community Health of South Dade.
- Economic Opportunity Family Health Center.
- Stanley C. Myers Community Health Center.
- Ann Marie Adker Over-town Community Health Center, Inc. (which has applied for Section 330 money, but as yet receives no federal or state support).
- Camillus Health Concern (Section 340 homeless health clinic).

- Public Health Trust/Jackson Memorial Hospital and its primary care clinics
  - North Dade Health Clinic
  - Liberty City Health Clinic
- Dade County Department of Public Health.

The following are associate members of the consortium:

- Dade County Area Health Education Center (AHEC)
- Operation Humanitarian Concern
- Health Council of South Florida
- Little Havana Activities and Nutrition Center

The Consortium holds monthly meetings of the Board of Directors, which consists of two voting representatives of each organizational member, selected at the member's discretion, All three levels of Consortium membership are invited to attend; organizational members have a reputation for perfect attendance, which speaks to the members' perception of the consortium's value. Board meetings are a forum for policy decisions, strategic planning, discussions of relevant issues, and new program proposals and initiation. Guest speakers from local or national health organizations are sometimes invited to meetings.

Assisting the Consortium's Executive Director and Board are various standing and ad hoc committees. Most of the standing committees address operational issues of the primary care clinics. They include the strategic planning, finance, nominating, medical directors, dental, nursing, and health education and nutrition committees.

2.2 Description of the Health Centers

This section contains brief descriptions of the health centers in the Dade County area, all of which are consortium members. The Consortium has provided individual fact sheets that detail geographic and funding information for each center. They appear in Attachment 1 of this report.

Borinquen Health Care Center, *Inc. (BHCC)*

Located in a high-poverty area within Miami, the Borinquen Health Care Clinic has traditionally served a multi-ethnic population, including many Latin American immigrants, and attracted much of its clientele from neighboring housing projects. Borinquen reports that greater than 50 percent of its users are Hispanic or from the Caribbean, the majority of whom are Haitian. Borinquen's 25,621 patients generated 66,604 visits in 1990.

The services offered by Borinquen include family practice, adult medical, pediatrics, obstetrics and gynecology, dermatology, dental, radiology, electrocardiogram, basic laboratory services, social and health service, outreach worker, and WIC services.

Coconut Grove *Family* Health Center (CGFHC)

The Coconut Grove Family Health Center is located in north central Dade County in the Coconut Grove community of Miami. The center is located in and provides services to a predominantly African-American population but also serves large numbers of Hispanics and Haitians. Coconut Grove is the smallest of the PHCCDC Community Health Centers, caring for 7,644 patients with 28,692 visits in 1990.

Despite its relatively smaller population base, Coconut Grove health services are consistent with those offered at larger health centers: family practice, adult medical, pediatrics, obstetrics and gynecology, minor surgery (sutures, etc.), cardiology, podiatry, radiology, basic laboratory services, dental, electrocardiogram, WIC, and an adolescent pregnancy program.

Community Health of South Dade, Inc. *(CHI)*

Community Health of South Dade is one of the largest community health centers in the country, CHI operates two primary health care centers in southern Dade County. CHI headquarters is located in the Doris Ison Health Center in the Gould/Cutler Ridge area. The Martin Luther King Clinica Campesina is located in the Homestead/Florida City area. In 1990, these centers combined to serve 62,134 patients in 161,404 visits. CHI patients are drawn from a multi-ethnic population.

In addition to its comprehensive primary care facilities, the Doris Ison Center operates a 24-hour Urgent Care Center, community mental health clinic, which includes an inpatient stabilization center, and a children's center that has a residential component for women and children.

The Martin Luther King, Jr. Clinica Campesina is also a comprehensive primary care clinic. It supports a fluctuating migrant/seasonal farmworker population of between five and eight thousand workers in addition to the area's permanent residents, which includes a significant fraction of indigent African-Americans. Outreach clinics are stationed near migrant farmworker camps.

Among the services available at CHI clinics are family practice, adult medical, pediatrics, obstetrics and gynecology, surgical, orthopedics, podiatry, cardiology, urology, vision, radiology, dental, basic laboratory services, nutrition, pharmacy, electrocardiogram, WIC, a mental health program, and some transportation services.

Economic Opportunity *Family* Health Center *(EOFHC)*

Although its clinical case load is slightly smaller than Community Health of South Dade, Inc., Economic Opportunity Family Health Center, is as extensive an operation as CHI. The EOFHC main facility is located in the northwest section of unincorporated Dade County in the Model City area: its four satellite health centers and residential treatment for chemically dependent women are located nearby. EOFHC treated 58,093 patients in 1990, totalling

130,000 visits. The center provides services to a predominantly African-American community, but also to a considerable number of Hispanics and Haitians.

EOFHC services include family practice, adult medical, pediatrics, obstetrics and gynecology, limited surgical, orthopedics, podiatry, pediatric surgery, cardiology, urology, dental, vision, radiology, basic laboratory services, nutrition, pharmacy, ultrasound, electrocardiogram, WIC, and specific programs on alcohol and substance abuse, hypertension, health education, and physical therapy. EOFHC is also able to offer transportation services to very needy and disabled patients. And finally EOFHC is known for its model program targeted at pregnant substance abusers which includes a residential program in addition to a day care facility for the children.

Stanley C. Myers Community Health Center *(SMCHC)*

The Stanley C. Myers Community Health Center is located in the South Beach area of Miami Beach. South Shore hospital is its neighbor. The center's service market has evolved from a chiefly elderly population to a clientele which is predominantly Hispanic and of childbearing age. Stanley Myers treated 13,940 patients with 52,290 visits in 1990.

The services provided to SMCHC patients include family practice, adult medical, pediatrics, obstetrics and gynecology, podiatry, cardiology, dental, radiology, basic laboratory services, pharmacy, social worker services, and WIC services.

Ann Marie *Adker Overtown* Community *Health* Center

The Ann Marie Adker Overtown Community Health Center, located in Miami near Jackson Memorial Hospital, has been operating since February 1992 as a private, not-for-profit center. Start-up for the center was provided with money raised by a fundraiser by long-time state senator Jack Gordon. The center had been given an administrator by Jackson Memorial Hospital and physician staffing from the University of Miami. Its service population includes especially impoverished African-Americans, and Caribbean-Americans, particularly Haitians.

2.3 Other Participating Agencies

Dade *Comfy Public Health* Department

The name Dade County Public Health Department may be misleading — the Health Department is actually an organ of Florida state government. This is the result of a mid-1970s contractual arrangement through which all county health authorities became the responsibility of the state's Health and Rehabilitative Services agency. The Department reports that 95 percent of its $55 million budget is supplied by federal and state governments, with the county donating no direct funding, with the exception of fees from environmental services.

The Health Department operates six primary care clinics which emphasize maternal and child health. In addition, they operate two satellite sites which specialize in communicable diseases; one comprehensive primary care center for refugees; one school-based health clinic and a foreign student clinic, each of which conduct school physicals; and 22 WIC service sites. The Health Department functions as the conduit for the state's Health Care Access grant, allocating these funds to the Dade County community health centers and to itself to ensure primary care services to the county's indigent patients. The Department of Public Health clinics handled 79,774 patients in 1990 who accounted for 663,689 service units (Unlike the CHCs which defines units by the number of medical encounters, the Health Department defines a service unit as a face-to-face encounter with a physician, dentist, or ARNP/PA nurse, health educator, or any other professional. Several service units may be offered at one visit.)

Public Health Trust/Jackson Memorial Hospital

The Public Health Trust (PHT) is the public health instrument of Dade County government. It has the responsibility for Jackson Memorial Hospital, the North Dade and Liberty City primary care clinics, two county funded nursing homes, and the primary care system in county prisons. Originally, the Public Health Trust and Jackson Memorial Hospital were essentially the same entity while the Dade County Office of Health Services operated the primary clinics, prison care, and nursing homes. In 1991, however, the Metro Dade Commission expanded the role of the Trust to be responsible for all county health services. Under the reorganization, the old Office was eliminated and essentially incorporated into the Trust's Ambulatory Care Division. PHT now considers itself responsible for the care of the county's indigent population.

As the only public hospital in Dade County, Jackson Memorial is the principal provider of secondary and tertiary care to indigent patients. It is teaching hospital of the University of Miami School of Medicine. In addition to providing nearly 1500 beds and comprehensive inpatient care, the hospital operates 130 specialty care clinics on campus.

Dade County provides approximately $160 million to fund the operations of the Trust. PHT also receives substantial patient revenues, funding by virtue of its relationship as the teaching hospital of the University of Miami Medical School, as well as awards and grants typical of a major teaching facility.

The Trust, charged by the County Commission to prepare a five year health plan for the county, is currently preparing a document that will be used as a guide for health care planning in Dade County. The Health Trust's Primary Care Committee will be generating the primary care aspect of the report. The voting membership of the Primary Care Committee includes Public Health Trust officials, including representatives from Liberty City and North Dade; consortium members are invited to attend meetings. A second committee, the Program Planning Committee, composed of only PHT members, is handling the secondary and tertiary aspects of the report. The Metro Dade County Commission, which is highly committed to addressing indigent health care, has also appointed an indigent health care task force to review these issues. The plans will be available in the next year or so.

Liberty City Health Clinic

The smaller of the two Public Health Trust clinics, Liberty City Heath Clinic treated 4,390 patients in 13,331 visits in 1990. As its name suggests, the clinic is located in the Liberty City section of the City of Miami. Three-fourths of the funding for the clinic is provided through the Trust by Dade County; Medicaid reimbursement accounts for nearly all of the patient revenue, as Medicare and self-pay incomes are negligible. Clinic physicians, nurses, and social workers provide services in general medicine, pediatrics, health education, sexually transmitted diseases, maternity and family planning services, and a WIC program.

North Dade Health Clinic

The North Dade Health Center is located in the northeast section of the City of Opa Locka, northwest of Miami, Its patient volume is approximately equivalent to that of the medium-sized community health centers. In 1990 the clinic treated 18,158 patients in 58,667 visits. The North Dade clinic receives more financial support than Liberty City from its patient base; while nearly 50 percent of its revenue is provided by Dade County, the state of Florida, Medicaid, Medicare, third-part insurance, and self-paying patients also contribute to its financing (although Medicaid provides the majority of this income).

Dade County Area *Health* Education Center

The Dade County Area Health Education Center (AHEC) is an independent, non-for-profit organization. The AHEC operates in an office located at the University of Miami **School but it also involves programs** for students at Florida International University and Barry University. The AHEC's board of directors includes executive or medical directors of the community health centers, representatives of the health department, and administrators from participating health schools. The 14 members of the board meet quarterly to review progress, set objectives, and implement changes.

The primary purpose of the AHEC is to encourage students, upon completion of health training, to pursue careers in primary care, especially in the medically underserved regions of Dade County. To achieve this goal, the AHEC is dedicated to integrating more primary care opportunities into existing training programs. In addition to medical and nursing student training, the AHEC has developed programs in nutrition, dentistry, pharmacy, psychology, and health administrative services.

In addition to providing these program training opportunities, the AHEC supports numerous other initiatives. The AHEC works actively through state and federal initiatives to provide financing for promising students and has initiated recruitment strategies aimed at minority students. The AHEC also sponsors continuing education programs that include courses targeted at community physicians, nurses, and allied health professional. The AHEC also works to provide access to library and learning center resources. And finally the AHEC sponsors services that promote access among students and other health professionals to **educational resources.**

Health Council of South *Florida*

The Health Council of South Florida is the health planning agency mandated by the state of Florida Office of Health and Rehabilitative Services. The state is divided into 11 planning districts; this office serves Monroe and Dade Counties. The Council's primary responsibilities are: to produce the district health plan, to conduct bed needs projections for the state Certificate of Need program, and compose the Certificate of Need allocations report. The Council also works with area health organizations on health planning documents and by providing data and counsel for various projects.

Operation Humanitarian Concern

Operation Humanitarian Concern is a non-profit group looking to develop a community health center dedicated to serving the needs of Haitian clientele.

Little Havana Activities and Nutrition Center

The Little Havana Activities and Nutrition Center is a private, non-for-profit community center which serves a mainly Cuban constituency. The Center's major activities include a food service program for the elderly and a day care center. The Center also receives a special grant from the State of Florida Department of Elder Affairs supporting physician participation.

South Florida AIDS Network

The South Florida AIDS Network (SFAN) is a consortium of Dade County health and social service organizations established to address health service issues for HIV+, AIDS, and ARC patients in Dade County. In particular, the organization is dedicated to insuring service delivery to patients who are not covered by health insurance. The Network is physically located in Jackson Memorial, but it is an independent entity with its own board of directors. The AIDS Network receives Ryan White funding and monies from the state of Florida and the city of Miami.

SFAN services include primary care services and case management for HIV+ patients, arranged through the Health. Care Consortium's primary care clinics and comprehensive social services for AIDS and ARC patients, including, for example, meals-on-wheels programs and transportation services. SFAN also coordinates educational and counseling programs for HIV+' patients.

CHAPTER III: COORDINATION EFFORTS

3.1 Factors that Characterize Dade County's Primary Care Coordination Efforts

Because of the diversity of health resources available to and the complex health needs of Dade County's indigent community, primary care coordination efforts are varied organizationally and in the issues they address. Nonetheless, Miami's coordination efforts generally can be characterized by the following:

- Two major consortia exist that represent the major providers of primary care services in Miami, the Public Health Trust and the Dade County Primary Health Care Consortium. The Public Health Trust, because Jackson Memorial Hospital is a major member, is oriented more toward primary care as it relates to hospital care. **The Dade** County Primary Health Care Consortium focusses more on primary care as it relates to community health centers since it is dominated and was originally set up to address the needs of community health centers.

- Miami's coordination efforts are distinguished by more hospital/community health center collaboration than exists in many communities, because the Jackson Memorial Hospital has been proactive, as compared to hospitals elsewhere, in working with community health providers both to decompress unnecessary demands on the hospital's emergency room and to make primary care delivery more rational overall.

- The Health Department does provide direct funding to the community health centers to provide primary care services to the indigent. However, unlike in Seattle, the health department does not try to leverage this funding to develop Miami's broader primary care delivery system. For example, though changes have recently been considered, the health department's dollar contributions are based on historical amounts trended forward and not on each center's actual change in demand or service needs.

3.2 Principal Primary Health Care Coordination Efforts

Urban Strategy Plan

Although the participants in the Primary Health Care Consortium had been interacting and collaborating for years, the framing of the urban strategy plan was the event that precipitated the incorporation of the Consortium in its current state. The formation of the urban strategy plan involved the principal Dade County providers of health care to the indigent — the community health centers, the public health department, and the Public Health Trust. The plan represents the first formal effort by these participants at enumerating what the

community's health care needs were, what resources were available, and how participants would work together to address them. The action plans detailed in the document formed the basis for many of the collaborative efforts which exist today, including a shared purchasing agreement, common Medicaid eligibility program, and an integrated management information/appointment scheduling system. In addition to the discrete programmatic achievements of this plan, the formation of this network of primary care leaders provided the nidus for subsequent-collaborative efforts.

Shared *Purchasing Agreement*

Following the enactment of the urban strategy plan, Jackson Memorial initiated a program that enabled all consortium members to purchase medical equipment and supplies through the hospital's discounted group purchasing contracts. However, the hospital's financial difficulties in the late 1980s undermined Jackson's ability to negotiate substantial discounts with its suppliers, and members were often obtained equipment and supplies outside the consortium. However, as Jackson's financial situation has improved, members have again begun to look to this arrangement to achieve discounts that they could not otherwise.

Common Eligibility

One of the cornerstone achievements of the Consortium has been its program of common uninsured indigent criteria. Prior to the urban strategy plan, primary health centers, public health units, and Jackson Memorial Hospital all maintained different patient eligibility criteria. Recognizing the need for common eligibility standards as a requisite to efficient referral systems, the members of the consortium united to establish one criteria which defined who would be eligible to receive services in Miami's indigent care system. Under this agreement, standards of financial viability are based on the Federal Poverty Guidelines. All parties agreed to provide treatment to patients who considered indigent by this standard. Patients need only register in one site to receive a card which allows them to access services at any of the Jackson Memorial Hospital service locations. This forgoes the need for duplicate registration and expedites appointment scheduling and inter-clinic referrals.

Integrated Management Information/Appointment Scheduling System

The existence of common eligibility requirements facilitated referral between the centers and Jackson's hospital-based outpatient specialty clinics. While common eligibility requirements eliminated the bureaucratic barrier of state duplicate registration, the practical barrier of the scheduling process remained. Using Health Care Access funding, Jackson Memorial designed and implemented an integrated management information and appointment scheduling system. Computer terminals are shared between the hospital and the community health centers: the community health centers purchase the computers at a discount, while the hospital supplies and updates the software and the requisite training for health center personnel. This hospital/community health center computer network allows for community centers to schedule patients at Jackson specialty clinics directly and vice versa. In addition,

the health centers can directly access hospital lab and x-ray results from the computer system and determine whether or not patients kept any scheduled follow-up appointments,

Immunization Supply and Delivery

The Dade County Public Health Department and the primary health centers collaborated to provide immunizations. The Health Department purchases serums, particularly tuberculosis and hepatitis vaccines, which it then supplies free to the community centers. The bulk purchasing power of the Health Department minimizes the cost of vaccinations and the decentralized pre-existing network of community centers provides a ready-made distribution network among the indigent population. The Health Department and the consortium collaborated on an infant immunization program grant to the CDC which has not yet been funded.

Cancer Ear/y Detection Program

The Cancer Early Detection Program is a joint program of the University of Miami School of Medicine's Sylvester Comprehensive Cancer Center and Jackson Memorial Hospital in coordination with area primary care centers. The program's goal is to decrease the breast-cancer mortality rate among medically underserved populations by providing mammography screening. The program especially targets women over age 40 and African-American and Hispanic women, who have been historically underserved by cancer detection programs. The American Cancer Society Center supplies the majority of funds for the program with Jackson Memorial contributing the rest. The screenings are conducted at seven primary care centers (including community health centers and the Public Health Trust clinics) and at the county health units. Each clinic is visited approximately once per week by the mammography screening van, which is staffed by two radiology technicians.

South Florida AIDS Network

The South Florida AIDS Network collaborates with various members of the Consortium to ensure heaith service delivery to the area's HIV+/AIDS/ARC patients. SFAN has arranged with the Consortium's primary health care clinics to provide primary health care services to HIV+ residents of Dade County. SFAN staffs an AIDS coordinator and at least one case manager at each of the area's primary health centers. These persons work to design health services for HIV+ patients and directly with patients to ensure their flow through the system. SFAN reimburses the centers for primary care, counseling, and laboratory services. In centers that do not operate their own labs, SFAN reimburses centers that send blood to outside laboratories for testing. SFAN has made arrangements with Jackson Memorial to provide inpatient AIDS care. Case managers at the primary care centers work with physicians to expedite the admissions process.

AHEC *Clinical Experience Programs*

The Dade County AHEC operates programs to provide clinical experience to health professions students by rotating them through primary care clinics. Each year the AHEC conducts a needs assessment of the community health centers and public health units to determine how many of what type of students the clinics need. Programs are then developed to match student interest with clinic need. Programs have been designed to provide clinic experience for students in all four years of medical school. Graduate level programs offer residency rotation programs at community health centers and public health units in family medicine, internal medicine, and pediatrics. Preceptor programs pair students with health professionals already working at community-based primary care facilities who, in addition to their normal patient caseload, spend time teaching and guiding students. These programs benefit the preceptors as well as the students ensuring that they remain up-to-date in their respective fields and providing them the opportunity to engage in reflective conversation about their practices and techniques. The AHEC is in the process of conducting a longitudinal evaluation of its programs' successes in recruiting and retaining health professionals, but since the AHEC has been in operation since 1986, not enough time has elapsed to yet evaluate the programs.

CHAPTER IV: LESSONS LEARNED BEST PRACTICES OF COORDINATION EFFORT

In this chapter, we describe the lessons learned/best practices elucidated from this site visit. We highlight in particular those factors that are of major importance to the development of coordinated primary care in Miami/Dade County.

Federal *Initiative* Brought Players to Table

HRSA was the catalyst for system-wide coordination in Dade County by requiring that providers unite to address local health care needs. In this effort HRSA played a dual role. First, HRSA promised to supply NHSC professionals and funding to develop supportive services if providers worked together to identify and respond to community-wide needs. Second, a senior HRSA official flew in from Washington to provide much appreciated technical support in helping providers work together to develop the "Urban Strategy Plan", a document that articulated those needs and the community's plan for addressing them.

Cross-Fertilization of Key Personnel

Many of Dade County's leading health care administrators have previous work experience as employees of related agencies. For example, prior to her current position as Senior Administrator of the Dade County Health Department, Annie Neasmann spent 20 years in the Public Health Trust's Jackson Memorial and for six years was the administrator of the North Dade Health Clinic. Jessie Trice, currently the Director of the Economic Opportunity Family Health Center previously spent several years as an employee of the Dade County Health Department. Understanding both the operations of and personnel in other agencies allows leaders to better identify and mobilize resources.

Earlier Unsuccessful Attempts at Coordination Later Facilitated Successful Efforts

Unsuccessful attempts at system-wide coordination prior to the Urban Strategy Plan provided forums for Dade County's health care leaders to learn about each others' goals, characteristics, and needs. While the Urban Strategy Plan marked the first time the members of the Primary Care Consortium actively collaborated as an organized body, agencies had attempted on earlier occasions to create a confederation to maximize area health resources. When the promise of National Health Service Corps physicians presented sufficient stimulus to finally unite area agencies, leaders were already familiar with each other both personally and organizationally and were better equipped to overcome territorial disputes and prior differences.

Active *Role of* Jackson Memorial Hospital in Primary *Care* Coordination

Unlike hospitals in many communities Dade County's public hospital, Jackson Memorial, is active in the planning, resource **support, and operations of community based coordination primary care efforts.** Jackson Memorial manages two primary care clinics and collaborates actively with Dade County's community health centers through the Primary Care Consortium and its own Public Health Trust's Primary Care Committee. The hospital recognizes the causal link between strong community-based primary care efforts and reduced dependence on expensive hospital inpatient and emergency room services. Because of its county financing and large patient base, Jackson is able to contribute money and other resources to coordination that would otherwise not be available. The hospital's progressive attitude towards health care induces it to apply these resources to coordination efforts like the computerized management information/appointment scheduling system and other projects.

Area Health Education Center Support

The Dade County Area Health Education Center supports coordination program with funding and personnel. The presence of health professions students in primary care clinics promotes physician recruitment and retention by providing'physicians with opportunities to teach and with faculty appointments at affiliated medical schools. In addition, the center provides educational programs that keep clinic physicians up-to-date on medical practices.

Consortium Provides Unique Forum for Coordination and Health Planning

The monthly board meetings of the Primary Health Care Consortium include representation from all the major components of the primary health care system in Dade County, providing a forum for group discussion and problem solving. The primary care committee of the Public Health Trust and the County Commission's indigent health care task force provide an additional forum. These group discussions lead to more systematic efforts to identify community health problems and ways to work together collaboratively to address them.

Institutionalization of Coordination Efforts

Since area consortia have been meeting regularly for more than seven years coordination efforts have become more routine aspects of agency operations; communication and collaboration within the system are becoming institutionalized. As testimony to the institutionalization of coordination, prior to the arrival of the new Executive Director, the Consortium had been able to operate for two years without a full-time administrator. While the administrators we interviewed recognized that the Consortium was operating more successfully and developing more rapidly under the direction of Ms. Cooke, they explained that it had met regularly and maintained its coordination program during those two years.

Organizations Work Cooperatively but Retain Autonomy

The Consortium is loosely confederated, allowing its members work to work together **while retaining their autonomy.** Community health centers, who serve mainly minority populations drawn from their local geographic areas, are especially sensitive to maintaining their organizational independence and patient base. A number of interviewees remarked that coordination efforts in Dade County were unsuccessful prior to the Urban Strategy Plan largely because of organizational mistrust and community health centers' desire to retain autonomy. The current structure of the Consortium provides a forum for health centers to relate their concerns, and address their needs in the context of the delivery systems larger resources, without the individual centers' having to relinquish their autonomy.

State Primary Care Association ***Initiatives***

The state primary care association has been particularly important in the development of coordination efforts, especially through its direct relationship with the state health department. A joint state health department/primary care association committee on primary care exists which is co-chaired by the state health officer and the president of the state primary care association. The committee has been instrumental in the development of the state health care access program. The committee works to help set the rules for allocating health care access dollars between the health centers and the health department. The committee has also increased the visibility of the health centers at the state level. This visibility has been important in the development of the state's Healthy Start program. This program includes local coalitions to plan for the use of state maternal and child health fund. Because of the state primary care association the community health centers are mandated members of the coalitions.

In Dade County, the primary health care association was instrumental in developing the coalition and has a subcontract to perform portions of the plan. The state association was also instrumental in Florida's early and full support of the Medicaid FQHC program. The association provided technical assistance to the State Medicaid office and to the community health centers.

APPENDIX F: SEATTLE, WASHINGTON

HRSA PRIMARY CARE COORDINATION
CASE STUDY SITE REPORT

CENTRAL SEATTLE COMMUNITY HEALTH CENTERS
SEATTLE, WASHINGTON

92LF0883

TABLE OF CONTENTS

CHAPTER I: INTRODUCTION

This, the fourth in the series of case study reports, examines the coordinated primary care projects of the Central Seattle Community Health Centers (CSCHC) in Seattle, Washington. CSCHC was established in 1976 to provide a centralized system for obtaining and distributing federal resources among its five member clinics. As such, CSCHC serves as the grantee and conduit for Section 330 grants (Community Health Center Program), Section 340 grants (Health Care for the Homeless) and Title X programs. Each of the five member clinics subcontract with CSCHC to provide primary care services under the federal grants, CSCHC also serves as the grantee for a Ryan while Title III HIV/AIDS grant and a Hepatitis B demonstration from Bureau of Primary Health Care (BPHC).

This report focuses on the coordinated primary care projects developed between CSCHC and its member clinics and CSCHC and other agencies and organizations as well. There are also extensive coordination projects that the member clinics, acting as free agencies, have developed independently, examples of which are described in this report.

To help the reader's understanding of the context for CSCHC's coordinated primary care programs, we begin by providing an overview of the Seattle community and the history, target market, and general services provided by the Central Seattle Community Health Centers and its member clinics. This overview is presented in Chapter I. The participating agencies and organizations are discussed in Chapter II and a general description of the coordination efforts in Chapter III. In Chapter IV, we summarize the "Lessons Learned and Best Practices" elucidated during the case study.

The Community

The five Federally funded health centers that comprise the Central Seattle Community Health Centers organization are located in the central and north central areas of Seattle/King County Washington. Situated in the northwest central region of Washington state, Seattle is the is the largest city in the Pacific Northwest. The city of Seattle, which is 20 miles long from north to south while only 7 miles wide at its widest point, is formed and partitioned by natural barriers. The city is bordered by Puget Sound to the west and Lake Washington to the east. Seattle is further divided into 14 neighborhoods, which are separated from one another by series of lakes, waterways, and discontinuous ranges of hills. The city's distinctive geography has a major impact on transportation and access from one part of the city to another.

Demographics of *Community* and *Center Users*

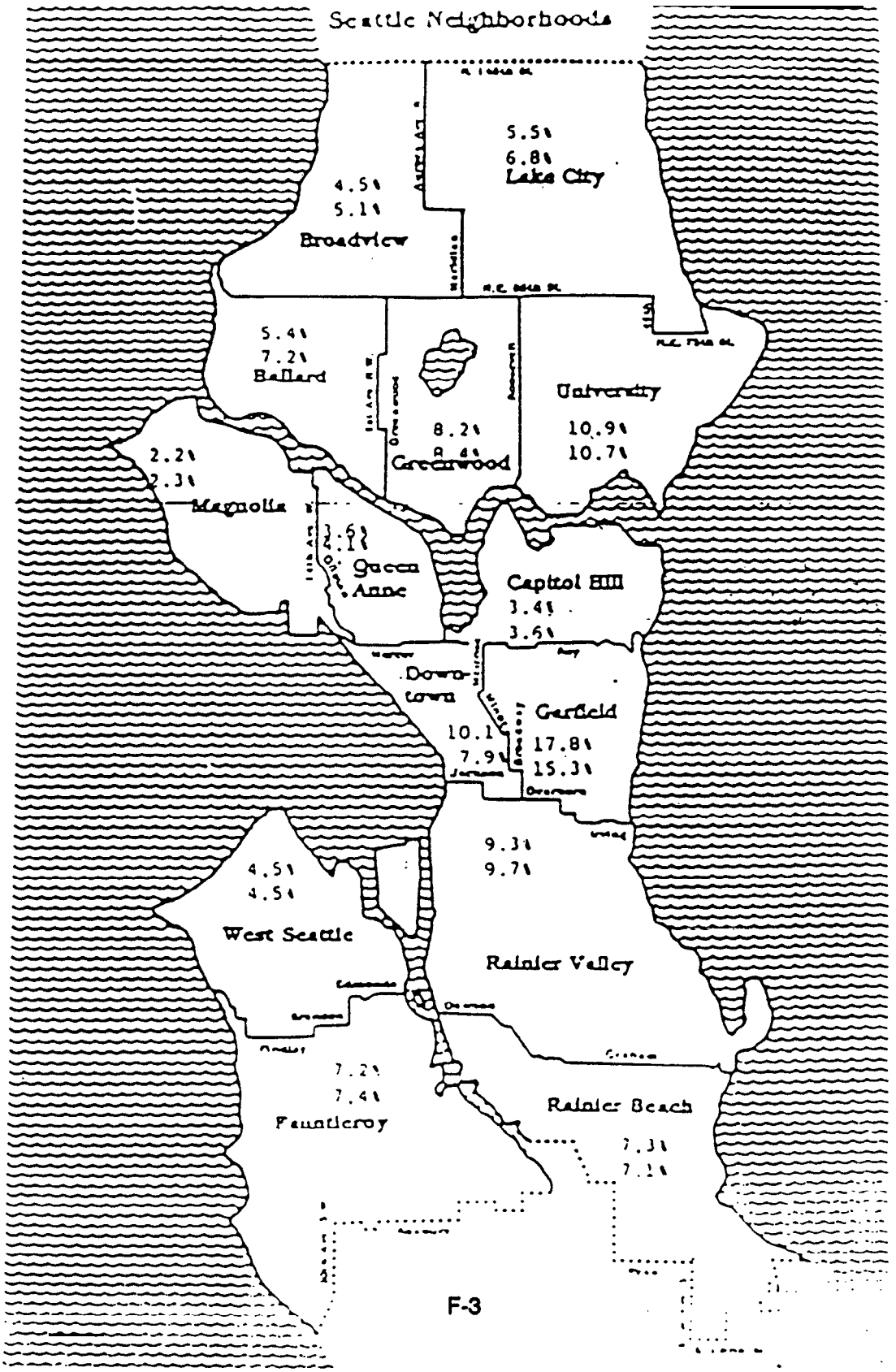
Seattle and surrounding King County are the most extensively populated areas in Washington state. **The majority of member clinic** users are from within the city limits, although some **county residents travel into the Seattle to make use of** CSCHC **facilities. The 1980**

census projected the 1990 populations of Seattle and King County to be 496,254 and 1,460,996, respectively. Approximately 33 percent of Seattle residents and 27 percent of King County residents were predicted to live below 200 percent of the federal poverty level. Between 1970 and 1980, the population of Seattle decreased 7 percent, a trend which was also projected for the 1980s.

Despite the decline in total population, the growth of Seattle's minority population was quite significant in the 1970s. Black, Hispanic, Native American, and Asian/Pacific Island residents comprise nearly one-fifth of the city's population and have grown at rates between 17 percent and 74 percent during the same period in which Seattle experienced population decline. A distinctive feature of Seattle's minority community is the recent influx of immigrants from Southwest Asia, many of whom speak little or no English.

The city's low income population is dispersed throughout Seattle's 14 neighborhoods and, although the majority of the racial minority population resides in the city's Central and Southeast neighborhoods, individual minority groups are not concentrated heavily in any one neighborhood. The figure on the next page of the distribution of people in Seattle's neighborhoods below 100 percent and 200 percent of poverty illustrates the dispersion of income groups throughout Seattle. From this illustration one might inaccurately conclude that hardly anyone is poor in Seattle rather than that the low income populations are scattered. As most neighborhoods do not contain a 'critical mass' of low income residents and ethnic ties are strong despite geographic dispersion, the placement of health services may be more dependent on transportation patterns than the desire for a 'central' location.

Figure 1
Map of Seattle's Neighborhoods



The CSCHC 1991 user pool included 25,989 individuals, according to its FY 1992 Section 330 grant application. More than 50 percent of this group were minority clients, 97 percent were below 200 percent of the federal poverty level, 63 percent had no medical insurance, and 8 percent were homeless. Despite the dispersion of various ethnic groups across the city each member clinic tends to be characterized by its service to specific groups.

Local Economy

Over the past fifty years, Seattle has developed from a mainly resource-based economy into a technological, industrial, port city. While logging, lumber milling, fishing, and farming continue to be important to the prosperity of the region, technological, manufacturing, and business service organizations have fueled much of Seattle's recent growth.

The services and trade sectors employ the largest fraction of the city's workforce, each accounting for just over 24 percent of non-agricultural wage and salary employment. Manufacturing accounts for almost 20 percent and government for nearly 14 percent of city employment. Seattle's port, which is the nearest continental American port to Japan, is the fourth largest in the United States and allows the city to be the gateway through which much Eastern trade passes.

Special Health Needs

The city of Seattle is plagued by health problems endemic to most urban centers. Documenting the severity of these problems has been complicated by the dispersion of the low-income population throughout the city. In some cases health data on low income populations are skewed by their dispersion in relatively affluent areas. Nonetheless, documented needs of the area's low-income population include perinatal care services, health services for the homeless, health services for HIV-infected persons, and health services for recent immigrants/refugees.

The need for perinatal care services for low-income individuals appears to be increasing as there are fewer obstetricians available overall and fewer still that render services to indigent popu!a?ions in Seattle. Recent trends have indicated increases in the already high rates of infant mortality and low birthweight. Access to prenatal care is most dire for minority mothers: the African-American infant mortality rate for 1988, the last year for which official statistics are available, was 24.5/1,000 live births.

The Seattle Emergency Housing coalition estimates that up to 25,000 individuals will be homeless this year, with 3,000 to 5,000 persons homeless each night. About one-third of the homeless population includes substance abusers and the remainder includes a growing number of children and pregnant women.

The health care service needs of HIV-infected individuals continue to increase each year. The Seattle/King County Department of Public Health currently estimates 10,000 HIV-infected persons in King County and has documented 1,609 cases of AIDS as of March 1990. Many of these persons lack medical insurance and family support systems.

The CSCHC FY 1991 Section 330 grant application cites an official count in excess of 100 new refugees monthly in addition to the 20,000 or so prior immigrants. These immigrants, who are often low income, rely heavily on the city's community clinics for care. Furthermore, bi-lingual and bi-cultural services are required for these immigrants, many of whom do not speak English.

Primary Health Care *Delivery System*

Seattle was avant garde in terms of developing managed care programs for the indigent but a latecomer in terms of its reliance on federal funds for primary care. Historically, community clinics were operated as a network of free clinics that relied on volunteer physicians and local funds. Organizations began to pursue federal funding in 1976 **when the National Health Service Corps (NHSC) made urban medically underserved areas eligible for NHSC** physicians.

The city's indigent are served by eight community health organizations that provide primary care in a total of 13 sites. These organizations include the CSCHC and its five member clinics. In addition, two of Seattle's hospitals and the health department operate primary care clinics. The health department operates two primary care clinics, a family practice clinic that is the north end's primary provider of indigent dare and a clinic in downtown Seattle. In 1989, 20 percent of Seattle's residents (60 percent of the low-income residents) received care from community clinics or health department clinics.[9] The city continues to lack sufficient private physicians to serve the primary care needs of the city's low income and minority populations.

Summary

The geographic and demographic conditions of the city of Seattle make the health service needs of the community especially complex. The city's health care system must confront issues of access and the cultural needs of various communities in addition to addressing the perinatal, homeless, HIV+, and immigrant health problems endemic to urban environments. Tables on the next two pages summarize and compare selected factors for the CSCHC community and users. The first page includes community and CSCHC-wide data; the second portrays user information for each of the five CSCHC health centers.

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9 **Thompson, Jack; The Community Health Svstem in Seattle and King County Washington: Historv. Present Issues. and Next Steps, Presentation at American Public Health Association Annual Meeting,** October 24, 1989.

SERVICE AREA AND USER CHARACTERISTICS OF THE Central Seattle Community Health Centers"

	SERVICE AREA [PERCENT]	USERS [PERCENT]
Race/Ethnicity		
White [Non-Hispanic]	72.0	47.0
Black/African-American [Non-Hispanic]	10.0	11.0
Hispanic/Latino [of any race]	4.0	8.0
American Indian & Alaskan Native	1.0	22.0
Asian/Pacific Islander	12.0	12.0
Other	1.0	0.0
Income		
Under Poverty Level	19.0	68.0
101-l 50% Poverty	13.0	19.0
151-200% Poverty	10.0	10.0
200+% Poverty	58.0	3.0
Insurance Status		
Medicaid	n/a	21.0
Medicare	n/a	6.0
Other	n/a	10.0
None	n/a	63.0
Special Populations		
Substance Abusers	n/a	2.0
HIV	n/a	1.0
Homeless	n/a	6.0

[10] **This chart has been adapted from the 1992 Central Seattle Community Health Center Section 330 Continued Funding Grant Application.**

CHAPTER II:
DESCRIPTION OF LEAD AND OTHER AGENCIES/ORGANIZATIONS THAT PARTICIPATE IN PRIMARY CARE COORDINATION EFFORTS

2.1 Central Seattle Community Health Centers

The Central Seattle Community Health Centers system consists of five health centers, ail of which are located in or around the downtown Seattle area and each of which focuses its service on a different population. The CSCHC, led by Executive Director William Hobson, serves as the central organization for receiving and dispensing federal funds to the clinics which serve as CSCHC's subcontractors for providing the federally funded primary care services. The five member clinics are otherwise autonomous, have their own boards, and are free agents when it comes to contracting with the health department or other non-federal agencies and organizations. Each clinic has its own director, appointed by the clinic's board. The five clinics include the Country Doctor Community Clinic, international District Community Health Center, Pike Market Medical Clinic, Seattle Indian Health Board, and the 45th Street Community Health Clinic. While each clinic offers services consistent with the needs of its target population, ail five provide comprehensive primary care services for the city's low- income population. Each of the five member clinics is described in Section 2.2.

A major impetus for the development of systems for more formal coordination across CSCHC's member clinics was the National Health Service Corps (NHSC). Soon after the Corps authorized NHSC physician placement in urban areas, community health clinics organized to develop a joint application to obtain NHCS physicians. The CSCHC continued as an efficient system to secure and coordinate and dispense other federal funds (e.g., grants). in addition, CSCHC also operates and/or manages three programs that benefit its members as well as other community providers serving the special populations (see Section 3.2). As such, CSCHC is both an umbrella organization for its members as well as a community-based provider of specific services (e.g., translation services; health promotion program).

Each of the five CSCHCs have served a somewhat different mix of ethnic and racial groups. This is in part due to their location and original missions. For example: international District CHC serves primarily Asian and Pacific islanders; Country Doctor and Carolyn Downs Community Clinics serve a significant segment of Seattle's Afro-Americans; and Seattle Indian Board is oriented toward serving Native Americans.

The Central Seattle Community Health Center organization consists of five divisions, as illustrated in the organizational chart on the next page. Under the guidance of the Executive Director, the Operations and Finance Managers oversee grant applications, contract management, accounting, payroll, and general organizational administration. The remaining three divisions (representing the three of the coordination projects described later

in this report), Interpretation Services (provided by CSCHC staff to hospitals and other primary care providers), the Sound Heart Program, and the Health Care for the Homeless program, are operational divisions.

All CSCHC activities are overseen by the Board of Directors. The Board of Directors includes a President, Vice-President, and Secretary-Treasurer. The Board is primarily organized to provide oversight for the CSCHCs including its activities related to federal grants and CSCHC-organized coordination projects. Member clinics operate autonomously under the direction of their own respective Boards that each meet the standards required of CHCs. Many of the CSCHC Board's functions are performed through the three standing committees described below:

- The Executive Committee consists of three to four members, including three officers and one consumer/user. If none of the three elected Board officers is a consumer/user representative then the Board elects a consumer/user representative to serve on the Executive Committee. The Executive Committee responsibilities include setting agenda for Board meetings, conducting financial reviews, and coordinating the annual performance evaluation of the Executive Director.

- The Medical Care Committee consists of the medical/clinical directors of each member organization and is charged with identifying system-wide problems and developing and implementing strategies to improve clinical program management. Medical Directors of three non-CSCHC centers also participate as ex-officio members of the committee.

- The Board *Development Committee,* comprised of three non-officers and appointed by the President, is responsible for developing nominating officers and for training members of the Board.

The CSCHC is an important vehicle for collaborative activities, including shared services arrangements (e.g., translation services) and development of joint grant applications. It is important, however, to note that each SCHC member clinic is responsible for its own operations and management. While each center maintains considerable independence, the Executive Directors have evolved mechanisms 'for sharing information and periodic meetings. For example, the Executive Directors of the individual centers also meet at least bi-monthly through the Executive *Director's Advisory Council* to discuss federal grant-related activities, other local initiatives and management issues of mutual interest.

Numerous public and private benefactors, including patient fees and all levels of government, supply CSCHC with approximately $8.5 million in revenue. Patient fees of $2.1 million account for 25 percent of the total and a Section 330 and Indian Health Service Grant contribute $1.9 million and $1.4 million, respectively. State, county, and local governments contribute approximately $2.3 million in total to member clinics. The United Way, private and in-kind donations, and private foundations contribute approximately $.8 million to the CSCHC and its member clinics revenue pool. Of the total revenue $216,000 funds the operations of the CSCHC. Of this, $143,000 comes through federal grant funding The following table details the sources of CSCHC's 1991 revenue.

on Capitol Hill, a neighborhood in which much of Seattle's gay community resides, and the Carolyn Downs Family Medical Center in the Central Area, home to 25 percent of the African-American families in King County. In FY 1991 the Country Doctor treated 7257 users, one-fourth of whom were African-American. This represents the greatest representation of African-American clients among CSCHC clinics,

Country Doctor identifies perinatal care, teen pregnancy, cardiovascular disease, and sexually transmitted diseases, especially HIV infection, as the most pressing health needs of its service community.

Both sites maintain a family practice focus, providing comprehensive primary care through Board certified general practice physicians, internists, physician assistants, and nurse practitioners. Other services include: pharmacy, dental, outreach, mental health counseling, and social service advocacy.

International District Community Health Center

The International District Community Health Center (IDCHC) was established to provide a comprehensive range of primary health services for residents of the international district and to other limited or non-English speaking Asian/Pacific Islanders, many of whom are first-generation immigrants. Asian/Pacific Islanders, in fact, comprised 98 percent of IDCHC users in FY 1991. IDCHC users numbered 2,226 in FY 1992. Some 84 percent of Center users were at or below the federal poverty line. This is the highest fraction of impoverished users among all CSCHC clinics.

Among the IDCHC user population, infectious and communicable diseases, mental health problems, substance abuse, prenatal care, and HIV infection are among the most severe health concerns.

IDCHC provides a full range of primary health services which include obstetrical, pediatric, and adult medical services; pharmacy; lab; family planning; nutrition counseling and WIC; social work; dental referrals; health promotion and education; and mental health assessment and counseling. IDCHC also employs a case management and medical records tracking system.

Pike Market Medical Clinic

Located in an area which contains a higher fraction of older citizens who often have multiple health needs, the Pike Market Medical Clinic (PMMC) serves a mostly adult population. More than one of five PMMC users during FY 1991 were Medicare patients. In contrast, in no other CSCHC clinic did the fraction of Medicare clients exceed 10 percent.

The Pike Market Clinic's elderly patients usually have multiple diagnoses, the most common of which are cardiovascular disease, respiratory problems, cancer, and debilitating arthritis.

PMMC services include medical care, laboratory, pharmacy, home nursing, mental health, social work, community outreach, foot care, and health screening.

Seattle *Indian* Health Board

The Seattle Indian Health Board (SIHB) serves Seattle's Native Americans and Alaskan Natives, who comprise three-quarters of center users. The user population, which totaled 7502 in FY 1991, is generally young. Many users are drawn by cultural ties with Seattle's surrounding Indian communities.

Among the unique community health concerns are alcohol/substance abuse, especially among youths and pregnant women, mental health, sexually transmitted diseases, and teen pregnancy.

SIHB services include medical, dental, nutrition, mental health, inpatient and outpatient alcoholism treatment, domestic violence counseling, alcohol and AIDS prevention programs, community education, and transportation coordination. Primary medical services include well-child, -adolescent and -adult care, family planning, perinatal care, geriatric care, and nutrition assessment.

45th Street Community Health *Clinic*

The 45th Street Community Health Clinic is dedicated to serving low income individuals in north central Seattle and King County. It is the only community health center serving these neighborhoods. Of the **45th** Street Clinic's 6,262 users in FY 1991, nearly 20 percent were homeless and 81 percent lacked any form of health insurance. The 45th Clinic has the highest fraction of Hispanic clients (20 percent) of all Central Seattle clinics.

The special needs of the target population include prenatal care, nutrition, preventive health, substance abuse, chronic diseases, and periodontal disease.

The 45th Street Clinic provides primary medical care for all ages including preventive, acute, 'urgent, and emergent medical health serves for both children and adults. In addition, the clinic provides comprehensive prenatal care, and comprehensive dental care.

2.3 Health Department Primary Care and Related Programs

Seattle has evolved a parallel structure of primary care clinics — private non-profit centers from the free-clinic era and public clinics sponsored by the county and city health departments. Increasingly, the latter are assuming a greater role in providing basic primary care services in addition to traditional health promotion and targeted services (e.g., immunizations; well-child clinics.

Seattle's primary care system emerged through a **series of collaborative** relationships between the private non-profit community health centers and the health

department's public clinics. A former three-term Seattle Mayor (1978-1990) was particularly instrumental in forging primary care delivery system alliances and supportive funding arrangements. Mayor Royer initially ran on a health care platform that sought to involve the CHCs. His Executive Assistant interestingly was a former Director of Country Doctor Community Clinic. Collaborative arrangements continue as does funding for CHCs. The public-private nexus continues. Several current health department officials had been leaders in Seattle's CHC movement. Jack Thompson, the current Health Director of the Seattle Division of the Seattle/King County Department of Public Health, has been Director of the Neighborhood Health Centers of Seattle (1978-1984).

Seattle-King **County** Health Department

Historically, the health department provided categorical services; more recently the health department provides primary care services as well through four clinics.

- North District clinic specializes in prenatal-maternity care, working closely with Swedish Hospital and its OB/GYN residency program. Services include on-site WIC and public health nursing.
- Downtown clinic offers various specialized services, including radiology and prescription drugs.
- Southeast area clinic specializes in pediatric and adolescent services, and is an example of a co-location, joint service delivery model, working with Puget Sound Neighborhood Health Centers, a family practice community health center.
- Central area clinic is the most recent co-location project, working with the Odessa Brown and Carolyn Downs centers.

In addition to its primary care outpatient clinics, the Seattle-King Health Department provides inpatient and outpatient substance abuse treatment services. As recipient of various NIAAA, NIDA and OTI substance abuse grants, the health department both provides and contracts for substance abuse treatment and prevention services. Health department substance abuse programs include: a free-standing detox center; 208 bed residential treatment; perinatal care program for substance abusing pregnant women and their children; contract services with 25 community-based organizations; and primary care-substance abuse linkage project (Bureau of Primary Health Care [BPHC] grant) with 4 community health centers.

Since the 1980s, the health department has been incrementally increasing its capacity to deliver primary care-personal health services. The current emphasis is on co-location and possible merger arrangements with near-by community health centers (e.g., Southeast and Central areas). A key informant, however, observed that the health department is "opportunistic" 'insofar as it will either provide or contract for services. For example, the health department maintains contracts with several CHCs for maternity care, channeling MCH grant funds. An overriding health department goal is to increase and improve the delivery of

primary care services. The health department efforts, thus, are directed as achieving its public health "assurance function" as set forth in the recent Institute of Medicine's public health study.

A very recent change in the Seattle formula for allocating funds ($4 million) for primary care centers may result in shifts of dollars among the community health centers. The new formula is population-based (corresponding with designated health service areas) rather than center-based. This potential shift in funding among the centers may shake-up the system, as one informant observed. The impact and implications are not yet known.

There is one potential area of tension in the collaborative structure that is emerging. The health department historically has been and continues to be a major source of funds and referrals for private community health centers. As the health department increases its own primary care delivery role, it may be viewed as a competitor for public funds (that finance primary care services and clinics) and for patients (especially in co-location arrangements or near-by neighborhoods). This potential tension was acknowledged but did not appear to be an immediate concern.

King *County* Division of Human Services

The King County Division of Human Services provides community mental health services.

2.4 Area Hospitals

Area hospitals are involved to varying degrees in collaborating with CSCHC. For example, Virginia Mason, is one of the hospitals to which member clinics' Medicaid and uninsured patients are admitted. Recently, Virginia Mason expanded its capacity to accommodate more indigent patients. In addition, some of its physicians are on a referral list to accept limited OB patients when no alternative capacity exists within the community or public clinics. Seattle's Community Obstetrical Referral Program (CORP) has received national recognition as a collaborative public-private program. Similarly, Swedish Hospital has maternity linkages with the health department's North District clinic. And, many CSCHC member clinic physicians admit and follow their patients at Providence Hospital. In addition, residents from Providence's family practice program complete outpatient rotations at a non-CSCHC community health clinic.

2.5 Private Sector Facilitators

United Way

While the United Way is not a traditional source of funding for primary care services, Seattle's United Way has played an important role at critical times. Most recently, United Way has provided funding for the community's medical interpretation services. (See

section 3.2 for more detailed descriptions of these CSCHC projects.) Its support of CSCHC was approximately $16,000 in 1991.

Most importantly, United Way funded Project Transition **in 1981, bringing together the key players — public and private —** when the Federal government precipitously cut-back funding for community health centers and the Community Development Block Grant Program. United Way assisted to mounting fund-raising efforts to generate $2 million within a relatively short-time. The Project Transition Committee, comprised of Seattle area foundations, major employers (e.g., Weyerhauser, SAFECO, Boeing), religious and other community-based organizations and government agencies assessed the level of Federal cuts and impact on community services, specific programs and population groups.

The Project Transition assessment of funding streams and cut-backs impact served as the basis for allocating $2 million strategically and to off-set the potentially devastating impact of Federal cuts on primary care and other social services in the Seattle area. Priority was given to community clinics (receiving almost half the funds), food banks, emergency shelters, and day care programs.

When asked why Project Transition was a success, the response was that there was a spirit of collaboration borne of necessity ("politics of scarcity can create community"). Another informant observed that there is a "northwest spirit" that reinforces cooperation and collaboration. This spirit is evident in the positive appellation — Project Transition — that conveys movement forward despite the precipitating circumstances. And, Project Transition leaders continued to support primary care programs with annual grants (e.g., United Way; SAFECO).

Northwest Friends ***of*** Comic ***Relief***

Comic relief is a not-for-profit organization that raises funds for the homeless. Comic relief has made donations to **CSCHC's** homeless projects.

CHAPTER III: COORDINATION EFFORTS

Many of the coordination projects began in the last few years or have expanded as CSCHC's leadership and funding services have stabilized. In this chapter we present an overview of the primary care coordination efforts, including overarching factors that generally characterize all coordination efforts. In addition, we discuss information on individual efforts including their objectives, primary services and activities, participating agencies, and funding resources.

3.1 Factors that Characterize CSCHC's Primary Care Coordination Efforts

We found the following characteristics to typify Seattle's primary care coordination strategy and activities. We provide these characteristics to provide an overview for the more detailed descriptions of individual CSCHC programs that follow:

- Federal resources came relatively late to the Seattle CHCs with the availability of National Health Service Corp physicians in the late 1970s. Within a relatively short-time, however, Federal funding cuts occurred. This led to the creation of strategic public-private alliances that continue to play a role in the evolution of local support for primary care and collaborative primary care projects.

- Since the 1980s, Seattle through its health policy (e.g., three-term Mayor Royer) and Health Department leaders — has made a commitment to building the primary care infrastructure and delivery system capacity.

- In contrast to many cities, Seattle has a history of collaboration that encompasses continuing involvement of key public agencies and private organizations. Some have referred to Seattle's collaborative efforts as reflecting the "northwest spirit".

- The Health Department has played a vital role in supporting community health centers, and continues to be a major source of funding for CSCHC clinics and other Seattle area CHCs (over $4 million in 1991). And, not inconsequentially, a number of the key Health Department officials had prior direct CHC experience (e.g., serving as Executive Director of a community health center).

- The Health Department, as a provider and funder of primary care services, is both a community health center advocate and increasingly a potential competitor. In terms of delivering primary care services, the Health Department now has a major presence with 40,000-50,000 visits per year. The relationships between the co-located public and private clinics are in the process of being worked-out, and they will require

nurturing in their initial years as the respective roles, responsibilities and services-sharing relationships are coordinated.

- Many of the coordination efforts described below are CSCHC projects and are characterized by formal agreements among the participating parties, There are, of course, additional collaborative networks and linkage relationships that CSCHC members have directly created (e.g., CHC-specific relationships with a hospital). Similarly, other private community-based clinics have evolved their own service delivery networks to broaden scope and accessibility of services. These are either formal or informal arrangements, depending on the circumstances and relationships among the parties.

3.2 Principal Primary Care Coordination Efforts

The primary care coordination efforts described below include a representative sample of the major collaborative efforts between CHCs, the health department, and other primary care providers. They are not intended to be inclusive; an inclusive listing is beyond the scope of this project.

Community Obstetrics Services and Referral Program

Seattle is characterized by a shortage of obstetric services for Medicaid and uninsured patients. To enhance obstetric services, CSCHC member clinics, the health department, the Virginia Mason Hospital, the Swedish Hospital, and the Providence Medical Center, and other health care providers coordinate services. For example, the health department funds a nurse midwife position at Virginia Mason Hospital. Two member clinics developed a joint OB call schedule to provide coverage.

The Community Obstetrics Referral Program (CORP), is a formally organized referral program that provides a centralized coordinated system for ensuring access to obstetrical care for indigent patients. Staff at the CORP maintains a list of available obstetrical care providers and rotate referrais among them. The CORP advertises their services on city buses, for example. Over 1381 pregnant women were referred to obstetrical care providers through CORP placements in 1981. Organizations involved in the CORP program include private obstetricians, the medical society, the local hospital council, community health clinics and the health department. The CORP is staffed by a full time Referral Coordinator. The program was initially funded through a grant from the Kellogg Foundation. The CORP has been operating for 10 years and has plans to install a computer system for more formal tracking and outcomes data.

*Sound **Heart** Program*

The Sound Heart Program (SHP) is a community-based cardiovascular disease screening and prevention program which has been operating in the Seattle/King County area since **1979.** Sound Heart, which was known as the King County High Blood Pressure Control Program from 1979-l 986, is the primary organization conducting cardiovascular disease-prevention programs in King County. It is also a member of the Minority Health Task Force Coalition. Sound Heart's staff operate and/or coordinate a network of blood pressure and cholesterol screening sites and provide education and medical referral services.

The Sound Heart Program targets those at high-risk for cardiovascular disease in Seattle/King County. Its primary service population is African-Americans and Asian-Americans. Low-income white and other ethnic minority groups are a secondary target market for the program. Services are primarily coordinated in Seattle's Central and Southeast neighborhoods.

In addition to being sponsored by the Central Seattle Community Health Centers, SHP has established working relationships across other health organizations such as the Seattle/King County Health Department, the American Heart Association, the American Lung Association, the American Red Cross, and the Group Health Cooperative in addition to local churches. These working relationships provide a basis for referrals, in addition to educational material, and updates on screening and treatment protocols.

Sound Heart's community health programs include educational presentation and cholesterol multi-risk factor screenings. These programs are offered free of charge at workplaces and community gathering places such as schools and churches. Educational presentations include information on a range of health topics but emphasize factors such as exercise and diet that affect hypertension and cardiovascular disease.

To staff its cholesterol screening and health awareness programs, SHP has developed a strong volunteer system. Volunteers are solicited at Sound Heart program sites and through public service announcements. They are then trained as Blood Pressure Measurement Specialists (BPMS) and counselors. SHP maintains a force of 50 active volunteers and of 100 trained and available volunteers. Seattle's Black Fire Fighters Association was affiliated with Sound Heart and consisientfy provided volunteers. All staff possess a degree in nursing, health education, nutrition, or medicine, are cross-trained by SHP to address issues of cultural diversity. The counselor pool itself includes members of various racial and ethnic groups.

In 1991 the Sound Heart Program conducted 516 multi-risk factor screenings, 286 for African-Americans. Sound Heart has been well received by the community and has maintained active relationships with African-American churches and other community organizations throughout its history.

The Sound Heart Program was awarded a DHHS Secretary's Award of Excellence **for health promotion/disease prevention programs in 1983. Sound Heart also received a two year competitive grant from the Office of Minority Health in 1987 for the development of community coalition activities focusing on cardiovascular health. The majority of the funding**

for the program is received through the Washington State Department of Health Preventive Health Block Grant Program and King County Current Expense Funds.

Medical *Interpretation* Services

The recent flow of non-English-speaking, mainly Asian, immigrants to the Seattle area has created the need for translation services in hospitals and physicians' offices. Addressing this need, CSCHC has established two medical interpretation services to facilitate the health care of non-English speaking patients. Through the Community Health Interpretation Service (CHIS) translators are located in 10 community health clinic sites (that include CSCHC member clinics and others as well), while the Hospital Interpretation Program (HIP) provides translation services to local hospitals.

Community Health *Interpretation Service*

The *Community* Health *Interpretation* Service program was founded in 1980 with a three-year grant from the private Northwest Area Foundation to facilitate translation services around Seattle's Community Health Centers. Prior to 1980 such services were only available at the International District Community Health Center. CHIS is staffed by a team of interpreters who rotate through community clinic sites, with blocks of time assigned to specific language groups on a regular weekly basis. Currently, the program is funded through a block grant from the City of Seattle, King County, and the United Way. CSCHC oversees CHIS through a Governing Council, comprised of representatives from the community clinics served.

Since its inception CHIS has provided interpretation for Vietnamese, Laotians, Thais, Cambodians, Hmong, Mien, and Chinese immigrants at community clinics. Recently other languages, such as Russian and Korean, have been added on an as-needed basis using hourly interpreters in an attempt to meet the changing needs of the refugee community. CHIS provides services at the following health clinics: Sea-Mar, Carolyn Downs, International District, Country Doctor, High Point, Rainier Vista, Holly Park, Southeast Dental, Georgetown Dental, Joe Whiting Dental, Eastside, Kent, and Auburn. In 1991 CHIS translators provided 8,232 encounters to 2,126 different clients in 15 different languages.

Hospital Interpretation Program

The **Hospital** *Interpretation* **Program** provides translation services to hospital patients free of charge. Translators are part-time employees with irregular hours who are called on an as-needed basis. Interpreters are on-call 24 hours a day to serve the members of the Seattle Area Hospital Council. The program is entirely funded by these hospitals who share costs on a utilization basis. CSCHC is the proving agency for the program. A committee of the Seattle Area Hospital Council is responsible for policy decisions,

HIP translators are available nine Indochinese languages; Korean; Spanish; Eastern European languages, such as Polish, Hungarian, and Romanian; Russian; and

several Ethiopian dialects. HIP interpreters visited 24 area hospitals and medical centers, providing 10,633 encounters requiring 13,794 hours in 1991.

Health Care for the Homeless

The Health Care for the Homeless Project (HCH) is designed to build upon the strength of the local community health system and its existing ties to the emergency shelter system. CSCHC stations interdisciplinary health teams (nurse practitioners, nurses, social workers, mental health counselors and substance abuse counselors) at shelters and day centers to facilitate health care for homeless persons. The shelter-based teams provide on-site care and refer patients to various agencies and organizations for primary care services.

While program administration is officially the responsibility of CSCHC the following organizations are contribute substantial capital and human resources to the project: the King County Substance Abuse Treatment System, Northwest Friends of Comic Relief, Harborview Hospital, Group Health Cooperative of Puget Sound (GHC), Harbor-view, and various shelter providers. The annual budget for the program is $1.2 million, which is raised mainly through Section 340 Health Care for the Homeless funding, in addition to city block grants, private fund raising, and a few private contracts. The program is supported in part by in kind contributions of staff by GHC and the Health Department. In 1991, 7,570 of the city's estimated 25,000 homeless received services through the program. The original funding for the Homeless project was supplied through the Robert Wood Johnson and Pew Foundations.

With the assistance of the King County Division of Alcoholism and Substance Abuse Services, HCH has trained its substance abuse counselors to redefine their services to be most effective for the treatment environment.

Member Clinic Medical Care Committee

The Medical Care Committee of CSCHC's Board is formally organized to oversee quality of care at member clinics. Over time the committee has provided an important and unique forum for medical directors of not just member clinics to come together to identify issues of mutual interest and concern. Many coordination projects have arisen from these discussions. The Medical Care Committee primarily deals with Quality Assurance issues and reviews member claim plans annually. Other priorities include specialty referral resource and inpatient care coordination, Well-attended Medical Care Committee meetings are held monthly.

Laboratory Courier Services

Since 1980 CSCHC has operated a lab courier service. Member clinics support the salary and fringe benefits of the courier and the health department supplies the transportation. The health department also performs the tests at reduced rates, except Chlamydia testing which is done at the University of Washington Chlamydia lab.

CHAPTER IV:
LESSONS LEARNED/BEST PRACTICES OF COORDINATION EFFORT

In this chapter, we highlight lessons learned from the site visit and potential "best practices" for possible replication. As with other site visit reports, we have organized the findings into "external factors" that facilitate collaboration (e.g., political and fiscal forces) and "internal factors" (e.g., CSCHC organizational and/or capacity development priorities). At this stage, we are primarily descriptive in identifying why and how Seattle serves an example of effective collaborative relationships. The relevance/implications of these findings will be addressed in a comparative cross-site analysis, to be presented in the final report.

4.1 External Factors

Historical Reliance *of Clinics on City, County and* State Funding

Collaboration between community health centers and the Health Department was promoted by longstanding health center dependence on local funding. Historically, Seattle's primary care services were characterized by a system of free clinics that relied on a tradition of volunteerism. As demand for primary care increased, clinics became more reliant on city as opposed to federal grant funding. In providing resources, the city worked with the clinics to ensure that resources were used strategically to avoid, where possible, duplication of services or service gaps. This contrasts with many other localities that sought federal funding and thus were less likely to depend on local sources (e.g., city, county or state) in building the private non-profit sector of CHCs. Seattle's health department thus played a far more significant and continuing collaborative role in forging the city's community clinic network.

Impetus of National *Health* Service *Corps* Legislation

Coalitions were promoted by legislation that made urban areas eligible to apply for National Health **Service Corp (NHSC) physicians.** The 1976 Federal legislation that permitted urban, medically underserved areas to apply for NHSC physicians was sponsored by Washington's Senator Warren Magnuson. And, Public Health Service officials encouraged Seattle centers to submit a joint NHSC application, and indicated that it would be viewed more favorably than a series. of competing individual-center applications. This collaboration laid the foundation for the CSCHC and relationships among CHCs in supporting other joint ventures.

The NHSC physicians also played an important role in forging positive relationships with other providers, particularly referral community hospitals. NHSC physicians

were viewed by hospital staff as being well-trained and thus valued additions to Seattle's health care sector, particularly as the demand for primary care by low-income, new immigrants and Medicaid rose.

Mayoral Advocacy for *Health* Department Support Community *Health* Centers

Local "enlightened" political support for CHCs was a major factor contributing to the development of collaborative efforts. Collaboration between the health department and community health centers was promoted by the Seattle city government in the 1980s. This was largely due to the efforts of an activist mayor who was elected on a health platform that emphasized public strong support for community health centers. The mayor's interest in community health centers was, in part, influenced and reinforced by his health policy advisor, a physician, who previously served as Director of Country Doctor (a well established Seattle center and member of the CSCHC). Various initiatives followed and were nurtured during the mayor's three term tenure.

Response *to* Unmet Needs

Collaborative joint-ventures achieved economies of 'scale in addressing special needs and unmet needs of target population. The Community Health Interpretation Services (CHIS) is one of many examples of coordination efforts driven by needs that could not be met without the combined resources and collaboration of multiple providers. CHIS began because no one hospital had 24-hour access to the full range of interpreters needed for Seattle's immigrants when they sought health care. CHIS developed a pool of interpreters speaking over 14 languages (Mien, Laotian, Hmong, Chinese and Russian, for example). These interpreters are specially trained and certified to provide translations for health care services. No one hospital has the resources needed to provide the range of translation services needed on a 24-hour basis, nor would it be particularly efficient to do so. The CHIS is an excellent example of how services developed by and for community health centers can be applied more broadly to serve the hospitals and, in turn, achieve economies and important primary care-inpatient linkages.

Geographic Considerations

Many interviewees related that Seattle's location itself promoted collaborative efforts. First, Seattle is a city noted for its community-oriented activism and spirit. Second, interviewees acknowledge that recruitment is somewhat easier since Seattle is viewed as an attractive place for practicing medicine. Seattle, for example, is noted for its physical beauty and more reasonable (as compared to some other cities) cost of living. Many of the coordination efforts rely on highly qualified and well-trained physicians to support collaborative clinical projects involving CHCs, hospitals and teaching programs.

Familiarity and Ease with Differing Organizational Cultures

Interviewees related that hospitals and community health centers learned to work together despite cultural differences. Hospitals viewed hospitals as the most appropriate site for all health care and were less cognizant of the outpatient services provided by CHCs. These perceptions were fostered by a general lack of communication regarding what each organization could provide. More recently dwindling hospital resources and an increasing reliance on hospital services by Seattle's indigent population has promoted an increased awareness of what each organization can provide. Hospitals look to collaboration with community health centers as a way to increase access to ambulatory care services and to avoid unnecessary and expensive dependence on hospital emergency room services. In addition, Seattle's hospitals increasingly look to community clinics as important graduate medical education training sites. Community health centers look increasingly to collaboration with hospitals as a way to provide inpatient continuity.

Willingness to look beyond cultural differences promoted collaboration among other participants as well. For example, where clinicians and social workers looked to one another for added expertise, collaboration was more likely to occur.

Regulatory Requirements

Certain regulatory requirements may encourage collaboration. For example, **making CON approvals contingent on evidence of collaboration facilitated collaborative efforts.** For example, when one of the local hospitals sought to expand its capacity, it was required to agree to begin provide a minimum number of deliveries to indigent obstetrical patients. This requirement enhanced access for these patients and promoted collaboration between the CSCHC and the hospital in delivering these services.

History of Collaboration *Between* Business/Private and Public Sectors

Over the past decade, private support for community health centers has been valuable. United Way's commitment, for example, to primary health care was critical in 1981 when it supported Project Transition and convened local business, foundations and public agencies to address problems resulting from major cut-backs in Federal funding. Local foundations and businesses support community health centers. The short-term effect of Project Transition was $2 million in private donations for community health centers and other hard-pressed social services. The longer-term effect was the building of private corporate and foundation support for programs that serve low-income populations. For example, SAFECO funds a parenting education program. United Way continues to provide core and special project support to community health centers. And, valuable relationships among key participants of Project Transition continue as their positions change but they meet periodically to forge and/or fund collaborative initiatives.

4.2 Internal Factors

Strong Non-Physician Leadership

As with prior site visits, strong leadership was consistently cited as important to collaborative efforts. Strong leadership was characterized as support for collaborative efforts, training and expertise, a desire to promote the interests of the community over the interests of any single organization, a track record of being able to get things done, and credibility internally as well as externally. In addition, interviewees related that leaders had to be innovative risk takers and able to facilitate collaboration across agencies with differing cultures and perspectives. Strong leadership existed across the CSCHC and participating organizations/agencies alike.

Strong Physician Leadership

Strong physician leadership promoted a myriad of collaborative efforts. Where member clinics were staffed by physicians who were noted to be strong clinicians and good teachers, collaborative efforts between member clinics and teaching programs developed. Teaching programs were active in pursuing those clinics, that were also well run and in desirable locations, as sites for resident rotations. In addition, strong physicians attracted other strong physicians, who were important in establishing credibility among other providers.

Focus *on C/ear/y Defined Access and Continuity of Care Problems*

Initial efforts to forge coordinated provider relationships focused on promoting continuity of care for pregnant women. Seattle as many other cities has serious problems in assuring access to obstetrical and maternity care services among its indigent populations. CSCHC clinics, for example, offered outpatient maternity and obstetrical services to lower income patients, but individual centers lacked reliable inpatient referral relationships with hospitals for inpatient care, specialized tests for high-risk patient and deliveries. While the CSCHC clinics had established an affiliation with Pacific Medical Center (previously Seattle's Public Health Service Hospitai), Pacific Medicai Center did not provide obstetrical services.

CHCs commenced negotiations with area hospitals — beginning with Virginia Mason. Two-party negotiations yielded affiliations, but the process was time-consuming and capacity problems persisted. At the center-level, collaboration resulted in three CSCHC clinics agreeing to share OB resources and set-up a joint call system to reduce pressures on individual centers' physicians. The 'affiliated hospitals, in turn, agreed to provide back-up.

Finally, with the assistance of a Kellogg Foundation grant, Seattle centers were able to design a more systematic approach for referring OB cases and assuring continuity of care (Coordinated Obstetrical Referral Program (CORP)). Over the past decade, the OB referral system has expanded to include several area hospitals and a roster of private practice obstetricians who agree to care for a specified number of pregnant women

The Existence *of* Formal Forums with *Broad* Representation

Formal forums that brought together representatives of different agencies and organizations on a regular basis promoted collaboration. One example is CSCHC's Medical Care Committee. This committee has active participation of member and non-member clinic Medical Directors. Collaboration is facilitated because it the committee provides a productive forum for Medical Directors to interact and identify ways to address common needs (e.g., how to coordinate physician coverage across clinics for example). Medical Directors actively participate because they view the forum as a productive one where real issues are identified and addressed.

Another formal forum is the Community Health Forum which meets monthly and includes representatives from: eight of Seattle's community health clinics, the Health Department, and local hospitals. A Chair is elected by the group that coordinates the meetings and ensures that minutes are taken.

Inter-Agency Participation *in Recruitment Decisions*

Collaboration was promoted because participating organizations were encouraged to participate in the recruiting staff for collaborative efforts. This involvement made participants more vested in collaborative efforts making these efforts more likely to succeed. For example, when the CSCHC recruited a case manager for the homeless project who was to spend a significant amount of time working in the homeless shelter itself, staff members from the shelter were encouraged to participate in the interview process. Ultimately, this led to wider support for the new recruit, ultimately facilitating the referral relationships across participating agencies.

Process/Communication

Interviewees related that good communication was a factor accounting for the success of coordinated projects, particularly where efforts were larger and more complex. Communication included involving as many people as possible in decision making. For example, where physician coverage schedules were to be changed, the CSCHC worked with each agency to ensure that changes were acceptable. Many interviewees noted that making changes without adequate communication or input risked the undermining of future working relationships.

Efficient Operations within Member Clinics

Interviewees related that clinics that operated efficiently were more likely to be more successful in collaboration efforts. Other organizations were more likely to want to collaborate with clinics that ran efficiently. In addition, efficiently run clinics were more likely to be viewed as desirable places to work by qualified applicants.

The Ability to Leverage Limited Staffing Resources

Limited staffing often led to the development of coordinated programs. In this site as with all previous sites, coordination was viewed as a way to leverage limited staffing resources. Where one organization had requisite case management resources it relied on other participants to supply clinicians to provide primary care services.

The Ability to Overcome Potential Bureaucracies

Health departments and community health centers alike viewed collaboration as a way to overcome potential bureaucratic constraints. In some instances (as we found in other communities), the health department was constrained in its ability to respond to needs due to, for example, union issues and regulations regarding funding streams. In those cases where health department flexibility was limited, it looked to community health centers to provide services.

Decentralization of *Collaborative Efforts*

Successful collaboration is dependent on a balance' of centralized and decentralized activities. While this site visit focussed on collaborative efforts at the CSCHC level, a host of additional activities were driven by the initiatives of the member clinics themselves, which acted largely as free agents in developing collaborative initiatives with other organizations (including the health department). interviewees related that the capacity to operate autonomously was important in cultivating a sense of ownership and in developing programs that were more responsive to the often unique needs and circumstances of the individual clinics.

Co-location of Health Department and Community Health Center Services

More recently in Seattle, co-location of health department and community health clinic services has been viewed as a way to promote collaboration and more efficient service delivery. A more recent co-location project involves combining health department pediatric primary care and WIC services in a new facility to be jointly occupied by a community health center that is in need of new space. CSCHC members and the Health Department have jointly worked to minimize potential obstacles such as referral patterns, medical records transfers, etc. Ultimately, overcoming these obstacles is viewed as a way to share resources more efficiently, in addition to obtaining needed new facilities.

Summary

As in other communities, a host of factors promote coordination of primary care services in Seattle. Perhaps, somewhat more unique to Seattle, but nonetheless important, is history of local funding and support for community health centers. The net effect is increasing emphasis on co-location (possibly merger) of public and private clinics, shared-

staffing arrangements and more formalized joint ventures. Effective collaboration appears to be a by-product of: (1) recognizing the value and importance of working together — in bad as well as better times; (2) a decade of experience and measured successes in forging joint programs; (3) the pervasive "northwest spirit" of activism; and (4) a durable cadre of "collaborators". And, communication channels are diverse, including various formal forums whereby key leaders regularly meet and identify further opportunities for collaboration.

APPENDIX G: CHICAGO, ILLINOIS

APPENDIX G:

HRSA PRIMARY CARE COORDINATION
CASE STUDY SITE REPORT

CHICAGO AND COOK COUNTY

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TABLE OF CONTENTS

CHAPTER I:' INTRODUCTION

This case study of efforts to coordinate primary care services in the City of Chicago is based on a site visit to the city in April 1992 by two members of the study team for three days. The visit was coordinated by the Illinois Primary Health Care Association, an organization playing a central role in several of the coordination efforts examined. This report describes the complex system of interlocking coordination efforts evolving in Chicago and explores the lessons that are emerging from the experience of a core group of participants who play a role in multiple separate but interrelated projects.

Chicago is a large and diverse **city** comprised of more than 75 identifiable neighborhoods, each -of which can be considered a community. Many of these communities are dominated by one or more ethnic/cultural groups, ranging across African-Americans, Hispanic-Americans, Native-Americans, Asian-Americans and Pacific Islanders, non-Hispanic White groups of various European heritage, and others. The economic status of the City's population varies from extreme poverty to considerable wealth.

Chicago is located on the western shores of Lake Michigan in Cook County, which includes a number of other cities and unincorporated communities whose demographics are similarly diverse. A number of these communities have been targeted as areas needing improved access to and coordination of primary care services and have multi-ethnic populations whose socio-economic status is similar to the poorer communities in the city of Chicago.

In 1989 the Chicago and Cook County Health Care Summit was initiated by Governor James R. Thompson, Mayor Richard M. Daley and Cook County Board President George W. Dunne. In support of this major examination of the health care system, extensive data were prepared examining the population distribution compared to the distribution of health care services and identifying needs at the neighborhood level. The recommendations resulting from this Summit divided the city and county into Corridors of Care for purposes of health planning and service delivery. Transportation, geography, ethnic/cultural mix, and many other aspects of ?he neighborhood character of Chicago were used in developing these Corridors. The corridors of care will be referred to throughout this report as the basis for many of the data available about health care, and specifically primary care services in the city and county."

The history, character, and politics of Chicago have been the subject of many publications and media events. It is difficult to understand anything about how things are done in Chicago without some understanding of this colorful city. The neighborhood character of Chicago dominates the environment in important ways. The City has long had a

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[11] **The population, economic and health care system data reported in this chapter are taken from the report that resulted from this "Summit' : Chicago and Cook County Health Care Action Plan, April, 1990, Volumes I, II, III.**

ward system of governance, with political organizations closely allied with neighborhoods and the distinctive ethnic/cultural and socio-economic interests vested in those communities. Many neighborhoods are represented by vocal advocates emerging from a tradition of grass roots leaders. City government has had a history of patronage. Many of the City's and County's leaders are struggling with maintaining the constructive aspects of neighborhood-based political influence, while trying to increase the credibility of agencies by decreasing patronage. Health care politics in the City and County have not, until recently, been characterized by any significant cooperation among agencies or jurisdictions.

Population

According to the 1990 Census, Chicago had an estimated population of 2.78 million, with racial distribution 42 percent non-Hispanic white, 41 percent African-American, and 17 percent Hispanic American. The minority population of the city has increased dramatically since 1970. Cook County, excluding the City of Chicago, had an estimated population of 2.3 million people, of which 79 percent are non-Hispanic white, 15 percent African-American, and 6 percent Hispanic. Its minority population has also been increasing.

The population in each corridor of care is summarized in Exhibit 1.

The "Summit" reports include details of changes in ethnic mix, and age breakdowns of the population over time and by neighborhood. We will not include such detail in this report. This data fails to capture the diversity of ethnic/cultural groups and their interaction within and among the neighborhoods that make up these corridors of care. However, we understand that neighborhood level data was available to planners and that public hearings held as part of the "Summit" process, involved considerable participation from neighborhood level activists.

Local Economy

Approximately 20 percent of the City's population has incomes below 100 percent of the federal poverty level, and nearly 40 percent have incomes below 200 percent of the federal poverty level. In Cook County, excluding the City of Chicago, less than 5 percent of the population has incomes below 100 percent and 14 percent has incomes less than 200 percent of the federal poverty level. (See Exhibit 2.)

EXHIBIT 1
1987 POPULATION BY CORRIDOR

CORRIDOR OF CARE	POPULATION	NON-HISPANIC % WHITE	% AFRICAN-AMERICAN	% HISPANIC
City of Chicago				
Northern	789,847	83.0	4.1	12.9
West Side	319,303	6.5	89.7	3.8
Near North	449,490	49.6	13.3	37.1
Mid South	269,759	50.9	6.9	42.2
Near South	188,755	19.6	78.7	1.7
Midway	398,871	58.8	32.4	8.8
South East	365,553	21.4	68.7	9.9
South West	240,335	29.7	29.7'2	2.2
Suburban Cook County				
North Suburban	298,790	80.2	16.6	3.2
North West Suburban	649,860	85.5	8.6	5.9
West Suburban	603,230	77.2	12.7	10.1
South West Suburban	275,690	92.4	4.5	3.1
South Suburban	479,270	66.5	28.8	4.7

12 **This data in Summit Report appear to be in error. Narrative data indicates dramatic increase in African American Population in this area.**

EXHIBIT 2
SELECTED SOCIOECONOMIC DATA BY CORRIDOR OF CARE

CORRIDOR OF CARE	POP. <100% POVERTY	POP. <200% POVERTY	MEDIC. NEEDY	MEDICAID
City of Chicago				
Northern	10.3	25.2	12.4	8.6
West Side	36.2	59.3	15.4	39.3
Near North	22.6	43.3	18.5	20.5
Mid South	20.2	44.6	25.6	14.8
Near South	44.3	65.7	13.0	44.6
Midway	16.4	34.2	9.4	20.8
South East	19.3	37.8	18.3	23.1
South West	14.4	31.4	13.7	20.2
Suburban Cook County				
North Suburban	3.6	10.0	7.8	0.8
North West Suburban	3.0	9.4	7.6	1.0
West Suburban	5.5	16.2	11.1	2.5
South West Suburban	4.0	12.4	8.5	2.5
South Suburban	6.9	17.7	7.7	8.1

The City of Chicago is home to many recent new immigrant populations as well as established groups who immigrated from other countries and areas of the United States. The erosion in the manufacturing sector over recent years has resulted in considerable unemployment and marginal economic situations for many families in the City, whose adult members may accept occasional labor, part-time employment, or have service industry jobs offering low wages and little or no health insurance.

Health Status

The city of Chicago has extensive health problems comparable to those in other major urban centers in the United States. (See Exhibit 3.)

EXHIBIT 3
SELECTED HEALTH MEASURES BY CORRIDOR OF CARE

CORRIDORS OF CARE	NEEDED AMB.[13] VISITS	GAP IN # AMB. VISITS	LBW% BABIES	LOW PRENAT. CARE %	TEEN PREG. %	YEARS LIFE LOST
City of Chicago	2,214,335	1,217,984	11	31	19	7,629
Suburban Cook County	1,095,012	1,041,215	6	15	6	4,155
Northern	527,927	448,297	7	25	8	5,221
West Side	265,723	123,252	14	35	29	10,585
Near North	449,697	275,413	9	27	19	6,555
Mid South	373,550	238,726	7	34	17	6,173
Near South	132,079	Surplus	15	42	29	10,967
Midway	202,678	75,794	12	32	20	7,406
South East	361,676	241,900	12	32	19	7,783
South West	177,260	57,484	12	29	21	7,477
North Suburban	123,995	123,995	5	11	3	3,312
North West Suburban	266,371	262,962	5	12	4	3,263
West Suburban	363,107	346,547	7	17	8	4,394
South West Suburban	126,128	125,455	5	15	5	3,806
South Suburban	199,546	172,343	7	21	12	5,075

Primary Health Care *Delivery System*

The health care delivery system in Chicago is complex and largely two-tiered with one system that largely serves the insured population, and another system made up of City, County, and private clinics and hospitals that serve the indigent population. Hospital care is accessible to the Medicaid and uninsured eligible population. However, primary care is limited by the distribution of physicians who accept Medicaid and other primary care resources available to serve the population with no coverage.

The Chicago Department of Health (CDOH) operates over 50 clinics and comprehensive neighborhood Health Centers located in medically underserved areas of the city, providing nearly 550,000 visits annually. Cook County Hospital outpatient clinics provide an additional 450,000 visits annually. The Cook County Department of Public Health offers approximately 80 clinics, meeting once monthly to supply primarily maternal and child health care with 24,000 visits annually. Another county hospital operates three primary care clinics

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13 Data on needed ambulatory care visits are based on medically needy multiplied by 5.4 patient visits per year. Source: National Medical Ambulatory Care Survey, 1988, NCHS. Gap in visits is determined by subtracting the public clinic and hospital and CHC visits estimated for each area, and therefore, probably overstates the needs, as physician offices and other uncounted clinics may provide some of this care. However, the information, while criticized as to its precision, is viewed in Chicago as a substantial measure of the level of relative need.

in the suburbs that total 24,000 visits annually. Federally funded private Community Health Centers (CHCs) operate at 20 sites providing approximately 200,000 visits annually.

Gaps in primary care services and barriers to access are discussed in detail in the Summit reports, According to all estimates, demand for primary care exceeds supply dramatically. HRSA has designated 32 communities in Cook County as Health Professional Shortage Areas. Most public and CHC clinics operate at capacity, and many have unacceptably long waiting times. (CDOH clinic waiting times doubled between 1987 and 1989 as budgets were cut and almost 600 city jobs eliminated.) Hospital emergency rooms and county hospital outpatient clinics have seen increases in visits and are operating at or beyond capacity.

CHAPTER II: DESCRIPTION OF LEAD AND OTHER AGENCIES/ORGANIZATIONS THAT PARTICIPATE IN PRIMARY CARE COORDINATION EFFORTS

While the lead agency and recipient of grant funding to support coordination efforts is the Illinois Primary Health Care Association, the Chicago Department of Health and the Cook County Bureau of Health Services are playing major leadership roles and contributing considerable resources to what has become a shared venture. A number of other organizations also play central roles contributing to the success of coordination efforts in important ways.

In understanding how coordination of primary care has evolved in Chicago, it is important to know that the magnitude of the problem would be impossible to address without considerable leadership from several segments of the City and County. **The leadership** roles of the three primary service delivery systems for poor are represented by the Illinois Primary Health Care Association (IPHCA). made up of private community health centers in the state; the Chicago Department of Health (CDOH) operating **more than fifty clinics; and Cook County Bureau of Health Services (CCBHS),** which operates county hospitals and clinics in Chicago and the suburbs. These systems have historically functioned in isolation from one another until the activities initiated in the mid-1980s began to bring about changes.

2.1 Lead Agencies

The Illinois Primary Health Care Association

The Illinois Primary Health Care Association (IPHCA) was incorporated in **1981** to represent and provide **assistance** to the community and primary care health centers in Illinois that are not-for-profit, governed by community-based boards, and organized to provide coordinated health care services to persons with limited incomes, public aid recipients, unemployed persons, migrant populations, and those living in Health Professions Shortage Areas. The IPHCA represents over **27** community and migrant health centers that provide services at over 70 locations for approximately 250,000 persons in the **state.**[14] IPHCA is a not-for-profit organization supported by funds from members and a variety of federal and private grants.

In 1987 IPHCA submitted a proposal to the Chicago Community Trust to establish a Primary Care Community Referral Network in Chicago. The proposal was revised and accepted by the Trust in January, 1989. Funding from the Trust supported staff and equipment to fulfill the following objectives:

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14 Description paraphrased from IPHCA materials.

- Create, operate, and evaluate formal linkages through written referral agreements and other means among selected community health centers, CDOH clinics and tertiary or specialty hospitals.

- Develop a Health Care Linkage manual describing the information gained from these and other linkage arrangements.

While IPHCA does not deliver health care services itself, the private, non-profit CHCs provide comprehensive primary care services for children, adults, and pregnant women. Some also supply dental services, optometry, and podiatry. A variety of other services are provided through these agencies, including but not limited to preventive health care, health education, services in the public schools, mobile health vans, laboratory, radiology, and substance abuse treatment.

The **Chicago Department of Health**

The **Chicago Department of Health (CDOH)** is one of the few municipal health departments in the country that operates a large clinic system comprised of both primary health and mental health centers, treating all patients regardless of ability to pay. The CDOH's clinic system in 1987 operated 57 distinct clinics in 43 buildings and included comprehensive neighborhood health centers, specialty primary care (e.g., MCH) clinics and mental health clinics. Its broad and inclusive mission has led, over recent years of strained budgets and increased need, to a crisis situation. As needs have increased, clinics have been closed and clinical positions eliminated due to lack of funds, resulting in increased waiting times for appointments and lack of access to meaningful primary care for many of the city's poor residents.

CDOH released an evaluation of the clinics' crisis in 1989, and a new commissioner came on board. The Commissioner is the former administrator of Mercy Hospital and a recognized leader with the ability to mobilize political attention and resources. She sits on the Steering Committee of the Linkage Project; senior CDOH staff are now intimately involved in the planning and operational aspects of all the coordination efforts related to primary care identified in this case study. The City has begun ongoing meetings with the County to explore closer coordination of services. A most recent accomplishment of these efforts is an agreement to develop compatible information systems.

CDOH clinics are largely financed from the city budget. CDOH has obtained FQHC status for its comprehensive clinics, enabling it to collect better Medicaid reimbursement. Historically, the city's ability to bill for third-party reimbursement has been limited, but this is being improved under the current administration. CDOH clinics also use sliding fee scales but collect little in fees from their patients.

The Chicago Board of Health, appointed by the Mayor, governs the CDOH. The subcommittee of this group involved with the cooperative efforts is the Clinic Oversight Committee, which was formed as a response to the Clinics in Crisis report discussed earlier.

The membership of this committee overlaps considerably with the Linkage Project Steering Committee.

Each of the CDOH Neighborhood Health Centers has a facility health board, which has a 51 percent consumer membership. The membership of these Boards is appointed by the Commissioner of CDOH. CHC and other community providers also participate on these Boards.

The Cook *County* Bureau *of* Health Services

The Cook County Bureau of Health Services (CCBHS) is a recently reorganized entity that has brought the county hospitals and the clinic systems together under one administration. Physicians at Cook County Hospital actually began initiating the first coordination efforts in the mid-l 980s when they initiated the Neighborhood Referral Project, which developed referral linkages between the Hospital and community health centers.

Since the reorganization of the county's health services, decision making is reportedly streamlined. The Director of the new CCBHS is the former administrator of Mt. Sinai Hospital in Chicago and is a powerful, visible, and well recognized leader in the health care community. Like the new Commissioner, she is able to work with the City's and County's leaders to engage them in the requisite political processes needed to move change forward. The County is now actively involved in the Linkage Project and has senior staff participating on its Steering Committee, as well as engaging in most of the planning and coordinating efforts underway in the City.

CCBHS operates Cook County Hospital and one other suburban hospital and is about to take over Provident Hospital in Chicago. Through Cook County Hospital, CCBHS operates the FANTUS outpatient clinics, which provide a comprehensive system of specialty and limited primary outpatient care. CCBHS also operates suburban clinics on a periodic basis providing primarily maternal and child health services, and sexually transmitted disease clinics. CCBHS services are funded primarily out the county budget. The hospital bills Medicaid and other third parties for eligible services.

The new CCBHS administration appears to be committed to improving the overaii management of county resources and services. The FANTUS clinic leadership seems to be motivated to do anything that benefits their patients. They are appreciative of the new resources represented by the Linkage Project and other proposed coordination efforts and use them.

The Cook County Bureau of Health Services is overseen by the County Board, an elected body. A subsidiary group functions as a Board of Directors for the FANTUS Clinics. Representatives of the CHC medical staff involved in linkages with FANTUS participate on this committee. County staff also have convened a planning committee for re-opening of Provident Hospital and include representatives of the CDOH clinics, the CHCs, other hospitals, and leadership from CDOH and the Linkage Project.

2.2 Description of Other Participating Agencies

Each of several other organizations contributes to the coordination of primary care in very different ways, which will become clearer in the next chapter when the coordination efforts themselves are described.

The **Chicago Community Trust**

The **Chicago Community Trust** played a major role in initiating coordination activities, A community foundation established in 1915, it has been committing approximately $30 million per year for programs in the Chicago metropolitan area. In 1986-87, the Trust committed $10 million to a four-year initiative called Access to Primary Care, and currently spends over $4 million per year on health care projects. The Trust funds the IPHCA as the lead agency in the Health Care Linkage Project and at the time of the site visit was considering a major expansion of that project proposed by the three lead agencies, with IPHCA serving as the grantee.

The Community ***Health Centers***

The **Community Health Centers** themselves, while members of IPHCA, are independent not-for-profit agencies, Those currently involved in the Linkage Project applied in response to an RFP and were selected based on a number of factors, including the strength of each center's administrative and medical leadership. The Administrators and Medical Directors are active in planning efforts, and some of them participate in the various committees involved in overseeing coordination efforts, While they work within the major coordination efforts described in this report, those we interviewed are also engaged actively in other inter-agency efforts to serve their local communities. Additional CHCs will be involved in expanding the Linkage Project if the new proposal to the Chicago Community Trust is funded.

The Chicago Department ***of Health Clinics***

The individual **CDOH Clinics,** while having little say about their involvement in the coordination efforts (since these decisions are made by CDOH management), clearly play an important role in the success of efforts to coordinate care. The Administrators of clinics work closely with their non-CDOH partners and engage staff in cooperating with agreed-upon protocols.

The **Cook *County*** **Hospital *FANTUS Clinic***

The **FANTUS Clinic** at Cook County Hospital is a critical resource for specialty care for patients using both the CDOH and CHC clinics. Linkage Project funds are used to

support staff at this clinic and the medical leadership is intimately involved with coordination. It was the medical staff at this clinic who initiated the first primary care collaborative efforts discussed in the next chapter as the Neighborhood Referral Program.

The University of Illinois School *of* Health Sciences

The University of Illinois School of Health Sciences participates in the committees that oversee some of the coordination efforts and is involved with one collaborative venture with the City at a City clinic site. The University's various professional training programs are involved with a number of the community health centers in providing medical residents and other professionals in training to enhance their experience in primary care.

The *Illinois* Department *of* *Public* Health

The Illinois Department of Public Health participates in the coordination efforts in Chicago and Cook County and contributes a staff member who plays a leadership role in the Linkage Project and participates in various committee activities.

Other Organizations

Other organizations represented and actively involved in oversight activities for the various coordination efforts include:

- The Illinois Department of Public Aid.
- The Civic Federation, a group representing a number of Chicago businesses.
- The Westside Health Authority, a community based advocacy group,
- The Region V Office of the US. Department of Health and Human Services.
- Private Physician.
- Private Hospital.
- The Hispanic Health Alliance.

CHAPTER III: COORDINATION EFFORTS

The efforts to coordinate primary care are interrelated both historically and by the overlap in the individuals involved in their development and oversight. The Chicago Community Trust's Access to Primary Care initiative occurred at about the same time that Cook County Hospital medical staff were beginning the Neighborhood Referral Program. These activities were followed by the Clinics in Crisis report evaluating of the clinic system of CDOH. The Health Care Summit was the major event that brought together the state, the city, county, and a host of agencies and consumer groups with an interest in the crisis **in primary** care access in Chicago and Cook County. The April 1990 report included recommendations for action to revise the system and called for extensive coordination.

'The overriding purpose of the Health Summit was to design a rational system of care which would be responsive to the medically needy. From the Summit deliberations emerged six themes, around which Summit recommendations are **clustered**"[15]:

- Breaking down barriers is essential for improved access to health care services.
- Community-based care must be expanded. Public health care services should be based in communities which are geographically close to the people who need them.
- The design of the health care system and its financing should promote appropriate care. Public expenditures for health care should maximize use of existing resources to assure coordinated, comprehensive and affordable services available system-wide. Public payors should be more prudent buyers.
- A balance must be achieved between public and private health system participants in meeting the needs of the medically needy in Cook County.
- Fragmentation of health services results in lack of continuity of care which promotes episodic, delayed or inappropriate use of health services.
- The capacity of the health care system must be expanded to meet the increasing demands of the poor and the medically needy.

For each of these points, the Summit provided specific suggestions buttressed by analyses and detailed plans. Recommendations built on earlier initiatives resulting from the Chicago Community Trust's initiative and the Cook County effort, as well as the Medicaid demonstration projects run by the state.

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15 See Summit **Report Vol.II, p.14,** Exec. **Summary.**

An important outcome of the Summit was the many recommendations that focused on specific types of coordination of primary care services among the three primary service delivery systems (CHCs, CDOH clinics, County facilities). Equally important was the focus on governance: a recognition that the problems and solutions proposed in this extensive effort would result in little concrete change without a fundamentally new approach to governing the health care system in the city and county.

3.1 Factors that Characterize Chicago and Cook County's Primary Care Coordination Efforts

A number of factors are consistent throughout the various coordination efforts and provide a context for understanding the distinct coordination efforts.

- In general, coordination efforts throughout the City and County are interrelated and administered by the same group of organizations. Project names associated with some of the efforts provide an identity needed to obtain grant and other funding and to facilitate communication, but these identified projects do not encompass all of the coordination efforts underway.

- The services provided through the coordination efforts are of two distinct kinds: (1) services to patients through the various clinics and hospitals involved; and (2) services to facilitate coordination itself. The basic service enhanced through the various coordination efforts is that of referring patients for appropriate care among the various health services. The referral process itself involves making an appointment for a patient and communication of information between the referring and receiving parties. Although this may seem to be a simple task, numerous barriers have historically prevented this from taking place. For example, appointment systems are not computerized, requiring someone to scan many pages of handwritten log books to confirm an appointment.

- The various coordination efforts underway are planned, monitored, and overseen by a number of committees. Two different types of organizational structures are involved: (1) those of the participating organizations themselves; and (2) those of the cooperative efforts. These committees have considerable overlapping membership and may be viewed as interlocking directorates.

- Contrary to popular one-stop-shopping being developed in some communities, the approach in Chicago and Cook County is to maximize the use of existing resources and to help move the patient from one resource to another. This approach is pragmatic rather than ideal. The actual coordination of services provide through these linkages is also very pragmatic, concrete, specific, and formal.

3.2 Principal Primary Care Coordination Efforts

The primary care coordination efforts described below include several of the major funded efforts that have a distinct identity. These efforts include collaboration among City and County health departments and community health centers as well as other organizations. There are many other coordination efforts emerging in relationship to these and other efforts to carry out the recommendations of the Summit, it is beyond the scope of this project to provide specific descriptions of most of these efforts.

The Health *Care* Linkage Project

The Chicago Community Trust has funded the IPHCA to implement a number of the recommendations from the Summit. The Health Care Linkage Project (HCLP) was funded to:

- Increase access by reducing waiting times, expanding the scope of primary care services, and increasing the capacity of the system to treat more patients.
- Improve the quality of care by increasing continuity of care, improving patient satisfaction, and both tracking and improving various health outcomes.
- Create a more efficient system by encouraging many providers to participate in prospective planning, enhancing coordination among providers, reducing duplication of services, and improving the cost-effectiveness of service delivery for the linkage network providers.

The project unites leadership from CDOH, Cook County, IPHCA, and the clinics involved as well as representatives from the business community, the University of Illinois, the state departments of health and public aid, and the federal Region V office. In addition it included several consumer representatives on its Steering Committee. This group began the nitty gritty process of figuring out how to link CDOH clinics that have unacceptable waiting times with CHC's having additional capacity, These linkages were made formal with written agreements.

The **Illinois Primary Health Care Association assumes** a critical role in providing staff support for the coordination efforts. The Executive Director and HCLP Project Director participate in numerous meetings of the Linkage Project Steering Committee, the Ambulatory Care Council, and various other oversight and planning committees. The other HCLP staff provide hands-on intervention with the linkage sites, problem solving, mediating, and collecting data. The perceptions of all informants are that IPHCA goes well beyond its representation role for CHCs and performs an indispensable mediating and facilitating role that enables all parties to work through mutually acceptable decisions on a case-by-case basis. The IPHCA also pays for staff located at the FANTUS clinic at Cook **County and for linkage coordinators who work from the CHCs**. These staff perform hands-on case management functions that will be described further below. Funding provided through the

Chicago Community Trust Grant for staff and equipment for the first two years was approximately $800,000. IPHCA estimates that these funds have leveraged $3-4 million in in-kind contributions from CDOH, CCBHS and participating CHCs.

The **Chicago Department of Health,** as the operator of a vast system of clinics, controls many of the resources targeted to be re-organized and better used. The Commissioner and her Deputy participate actively in the many planning committees. However, their primary involvement is in enabling their bureaucracy to respond to change. Through the HCLP and the linked clinics, all levels of management are involved with detail related to the management of the linkages. CDOH managers will bring linkage problems to the attention of the HCLP staff and director.

The **Cook County Bureau of Health Services,** as the primary resource for hospital and specialty care, and secondarily a clinic provider, controls extensive resources that are severely strained. The staff of the CCBHS participate actively in planning activities. The leadership in the actual coordination efforts seems to have come from the public health physicians who practice in the FANTUS clinic. These physicians are deeply involved with many of the problems their patients face in navigating the systems. They contact the HCLP staff for assistance and are supported by HCLP-funded staff on site.

The HCLP has a Steering Committee with an Executive Committee and subcommittees for Operations, Evaluation, and Policy. The Members of the Executive Committee include the Committee Chair, a representative of the Illinois Department of Public Health, a physician staff member from the DHHS Region V office, and a consumer representative from the Westside Health Authority. The HCLP also has Linkage Oversight Committees for each of linkage sites including a CHC and one or more CDOH clinic sites.

The HCLP has formal written agreements among each set of linkage partners. Other referral arrangements operated under other programs or informally do not always have written agreements. Written agreements are particularly important when any CDOH facility is involved. Over the course of two years, formal linkages have involved nine CHCs and seven CDOH clinics, as well as Cook County Hospitals and clinics. HCLP funds a linkage coordinator at the Ambulatory Screening Clinic at Cook County Hospital to integrate HCLP with the Neighborhood Referral Program. Each agreement is different and is based on the capacity issues faced by each linkage partner.'

For example, a CDOH maternal and child health clinic one block away from a CHC has more than a month's wait for prenatal care appointments; and the agreement specifies that the CDOH clinic will check the waiting times at the CHC; and, if they are shorter, will send new patients to the CHC. Families that no longer qualify for care at the CDOH-MCH clinic due to their children growing older may also be referred to the CHC. These clinics had operated in close proximity to each other for many years and never cooperated until the HCLP identified the least-threatening area for cooperation. Historically, the MCH clinic would view the CHC as competing for their patients, and for their jobs.

Another example is a CHC making referrals to a CDOH clinic for dental services for their patients. **Cook County Hospital's screening clinic also tries to refer Spanish-**speaking patients to a particular CHC that has a large number of Spanish-speaking staff,

including physicians. A CHC that wants to build a practice for its internists solicits referrals from Cook County for adult patients, Numerous additional specific referral arrangements are developed and managed through the HCLP.

Neighborhood Referral Project

Historical barriers and logistical problems have prevented a smoothly operating system of referral to be implemented in Cook County. One particular problem has been a lack of familiarity with different clinics' resources by physicians and an unwillingness to refer patients without assurances that the receiving physician will communicate effectively back to the referring physician. Cook County Hospital's Neighborhood Referral Project addresses this problem by having physicians work in both the FANTUS clinics and a CHC site. Having seen the CHC and knowing the physicians and staff, these FANTUS physicians were more comfortable making referrals to the CHCs, and communicated their experiences to their colleagues. The proposed Physician Referral and Linkage Project pending funding, would build on this experience and institutionalize it by establishing a number of physician positions shared between Cook County and comprehensive community clinics.

The Ambulatory *Care Council*

The Steering Committee of the HCLP includes much of the leadership from another group intended to carry out the governance goals of the Summit, the Ambulatory Care Council (ACC). The HCLP is described by some as a bottom-up effort to change the system. The ACC is intended to provide its top-down counterpart. In 1991 the Chief of the newly formed Cook County Bureau of Health Services and the Commissioner of CDOH met with the Cook County Board President and the Mayor to explore the implementation of the Summit's recommendations. A mini-summit was held that summer, from which emerged the ACC, co-chaired by the Chief of CCBHS and the Commissioner of CDOH. It is charged with creating an implementation plan for restructuring and integrating the fragmented system of ambulatory care in Chicago and Cook County. The ACC held a planning retreat in early 1992.

The ACC is co-chaired by the Chief of CCBHS, and the Commissioner of CDOH. It has the following Subcommittees: Resource Allocation, chaired by the Project Officer from the Chicago Community Trust; Finance and Governance, co-chaired by a CHC Executive Director and a University of Chicago physician from the chronic care children's hospital; Clinical Effectiveness, co-chaired by a RN involved with the Families with a Future Project and a physician from the County; and Systems Management, co-chaired by the HCLP Director and the CEO of Bethany Hospital. Two senior staff from the CCBHS and CDOH staff this committee.

New Initiatives Pending

The IPHCA, the CCBHS and the CDOH have together submitted another proposal to the Chicago Community Trust to expand and build upon the HCLP over the next three

years. This proposal, called the Ambulatory Care Integration Project, was in the process Of submission at the time of the site visit. Funding requested from the Trust includes approximately $1 million for year one and $1.3 million for year two, with no request for year three pending efforts to obtain $1.3 million from within the system. This proposal would continue the staff from the HCLP and add district coordinators and administrative support staff and equipment to support a broader effort. Linkages would be expanded to other areas as well as to the hospitals.

Another proposal for funds from The Robert Wood Johnson Foundation is pending to develop a pilot project to improve access to primary, diagnostic and specialty outpatient care for the indigent in Chicago and Cook County and to establish incentives for ambulatory care delivery in a coordinated, cost-effective manner. This proposal represents the collaboration of several Chicago area foundations and was approved by the ACC. The grantee would again be the IPHCA; the HCLP Director would also direct this project. The project would involve the joint hiring of physicians by Cook County Hospital and a community health center. The physicians would work part time in each site, facilitating referral and continuity of care between sites.

Other *Coordination* Efforts

Other efforts that do not clearly fall within the scope of those described above include:

- Partnership in Health regional model: CDOH, Mt. Sinai Hospital and St. Anthony Hospitals began providing care to at-risk and increasing-risk pregnant women referred from three neighborhood health centers. Arrangements have not yet been made for high risk prenatal care, though Mt. Sinai has provided some of this care. The hospitals hired patient services coordinators to work at the neighborhood clinic sites. These services are provided through joint planning and have involved adaptation of forms and procedures to eliminate duplication of effort.

- University of Illinois Health Sciences Center, CDOH, and Bethany Hospital cooperated to expand primary care services provided in the Austin neighborhood in coordination with a neighborhood-based organization that established a medical office building year St. Anne's Hospital which was closed and temporarily converted to alternative use. Neighborhood opposition to the closing of the hospital resulted in grass-roots organizing to establish an alternative medical presence in the neighborhood. This effort was initiated and facilitated by CDOH staff

- Suburban Primary Health Care Council's Access to Care Initiative sponsors primary care referral programs in areas of suburban Cook County. Begun in late 1988, the system uses a capitated system to encourage primary care physicians to provide services to a predetermined number of uncompensated patients. It uses physician contracts and has a physician advisory panel that reviews the

determination of covered services. Patients make small co-payments. Patients have incomes less than 200 percent of the federal poverty level and do not qualify for Medicaid.

3.3 Measures of Success/Project Evaluations

With the evaluation of CDOH that resulted in the Clinics in Crisis report and the Summit activities and reports, an effort has been made to quantify the extent of the problem and measure the effects of problem-solving efforts in increments. The primary measure of progress on a day-to-day basis is the measurement of appointment waiting times. This is conducted, although not uniformly or systematically, by all participants on an ongoing basis. Patient waiting data serve as a quantifiable proxy for patient needs, something all participants share as a concern, Changes in procedures are made rapidly in response to increased waiting times, particularly for pregnant women.

A second measure that is tracked and reported to oversight committees on a regular basis is the referral completion rate. Some tracking is being done to see if patients stay in the system they are referred into, as opposed to keeping an appointment or two, and then reverting to a previous source of care. This data, where they exist, are promising and were reported by clinic staff during site visits. They are collected by the IPHCA staff and provided in written reports to the HCLP Steering Committee.

Apart from formal evaluation, informants interviewed during the site visit expressed consensus that the efforts undertaken to date have been successful in a number of important respects:

- The players are still playing. Given the political history of the Chicago area, this is no small accomplishment.
- Providers who share a target population are becoming acquainted, improving their understanding of each other's way of doing business, and decreasing their turf concerns, or at least minimizing the interference of politics in providing patient care.
- The system is learning from heroic effort to solve problems for individual patients. Those making the efforts are beginning to feel that they are rewarded by more than the satisfaction of having helped an individual patient.
- The system is documenting its real capacity to provide services; the areas where service capacity must be added are emerging with the documentation of need essential to secure required funding.
- The ACC represents a proto-governance structure: a move toward establishing a unified authority to finance and deliver health care services for the poor in the area. Whatever this entity is ultimately called, it is viewed as bringing the top of the system which controls the resources

into communication with the bottom of the system that delivers the services to patients. While top-to-bottom-to-top communication may exist in other communities, it has been unheard of in the Chicago area and is viewed as a major accomplishment, even when limited to such issues as referral of patients from one resource to another.

- The longer the linkages continue, the less vulnerable they will be. As coordinating parties become used to working together, it makes less difference who runs what.

- Clinic staff perceive a better patient flow and believe patients are getting more services that they need with fewer problems.

CHAPTER IV: LESSONS LEARNED AND BEST PRACTICES OF COORDINATION EFFORTS.

Prior to our site visit the participants in Cook County's coordination efforts had already begun to examine some of the factors which make their coordination project successful. This chapter begins with a review of their analysis, which appears in the Health Care Linkage Project Manual, specifying techniques and practices that have contributed to the successful operation of their coordination projects, Through interview and observations, during our site visit we identified additional factors which have contributed to coordination success,

4.1 Lessons Learned as Described by the Health Care Linkage Project Manual

The IPCHA's Health Care Linkage Project staff developed a manual which captures lessons learned from the experience of two years.[16]

- **Patient-Level Lessons**

  Patients need to be educated as to how to use the clinic systems.

  Patients need to have the option whether or not to be referred.

  Providers need to give out the message that the referral provider is "approved of".

- **Operational-Level Lessons**

  All key people must be involved as early as possible. Enough cannot be said about the extent of communication and the attention to detail required to implement linkage relationships.

  Informality does not work. Formal agreements and instructions with attention to detail are essential.

  Ongoing staff education is critical. Needs assessment and training need to be shared activities across jurisdictions.

  A dedicated staff person to facilitate and follow-up the referrals is important, particularly when automated appointment and medical record systems are not available. The role of the linkage

[16] This information is paraphrased from the IPHCA HCLP Manual.

coordinator involves, client tracking, a limited type of case management, and a vehicle for building trust among the staff of linked provider organizations.

Compatible data-collection mechanisms are necessary to support planning and problem solving. A mechanism to share medical records is imperative. A compatible medical record among providers would save lots of time and improve communications.

Brochures for use with patients are important to support the marketing of referrals to patients and to the community.

The administrative costs underlying the coordination of services (e.g., linkage coordinators, among others) must be financed and are not recognized by conventional funding sources.

Fee schedules need to either be compatible, or mechanisms need to be found to avoid creating disincentives for patients to follow-through on a referral.

- **System Level Lessons**

Developing relationships takes a long time; it cannot be rushed. It takes considerable facilitation, mediation, and communication.

- The potential for misinformation, false assumptions and destructive rumors cannot be understated. The HCLP found that providers located within a block of each other for many years had never visited each other or been on each other's premises. Further, public events such as a speech by the Mayor about privatization, affected the perceptions by employees that linkage was a ruse to eliminate their jobs, Such perceptions proved to be a barrier in engaging the CDOH clinics in linkage participation at the direct service-employee level. Whatever management wants, if employees approach change with fear, they will sabotage the effort.

All levels of staff need to become involved in implementing linkage agreements, to promote mutual trust and create accurate impressions of the goals and objectives for the tasks that will change.

Active involvement from staff at all **levels** in the CDOH is particularly important in engaging the cooperation of the CDOH clinics in the nuts-and-bolts implementation of the linkages, **particularly as systemic issues emerged.**

Expanding linkages to include hospitals has been more difficult and complex than imagined and needs considerably more attention in the next phase of the project.

- Formal linkages result in unanticipated spin-offs as staffs at linked organizations identify further opportunities for coordination. These opportunities can be acted on, often without the formal agreements needed to start the original relationship. Examples of such spin-offs include: A CHC developing an STD clinic to help unburden an overcrowded CDOH clinic; CDOH staff providing specialized training to CHC **staff;** and HCLP providing technical assistance to hospitals seeking their own linkage arrangements.

4.2 External Factors

The external success factors that we identified included the involvement of state and federal officials and leverage provided through access to federal resources.

Involvement of State and Federal Officials in Health Planning Efforts

The success of the coordination efforts in Chicago and Cook County is due, in **part, to the integration of representatives from organizations external to the City and County into planning efforts.** Representatives of the Governor's office and state agencies, as well as senior staff in the federal Region V office play visible and active roles on several of **the key** planning, oversight and policy making committees. The participation of these individuals has helped to link primary care coordination planning to other efforts in the state, such as Medicaid demonstration projects. It also has helped to improve information flow about state'and federal initiatives. Finally, it lends increased credibility to the collaborative oversight bodies when seeking funds from private foundations.

Leverage Provided through Access to Federal Resources

The impact of federal grants, availability of federal monies, and placement of Public Health Service physicians all were identified as events that leveraged resources far beyond the scale of investment by the federal government. Many of the physicians involved in the linkage efforts were placed in Chicago through the U.S. Public Health Service. They have stayed and **become invested in the communities in which they 'work, the institutions** they work **for, and the patients they care for.** They have generated ideas to move various coordination efforts forward, and give of their _own time to sit on the advisory boards of cooperating providers.

The ability to obtain Federally Qualified Health Center (FQHC) status **for city and** county clinics was credited with the progress the City and County have **been able to achieve by demonstrating to their own governmental budget authorities, their ability to bring in**

revenue and contribute some resources back to the system which funds most of the services. Similarly, FQHC has enabled the CHCs to leverage their other funds to provide additional services needed by their target populations. FQHC was clearly viewed as a capacity builder.

The availability of federal resources has provided incentives for groups to cooperate to obtain and use funds. In cooperative planning and grant writing, groups with little history of working together found common interests, learned more about each other and their communities, and discovered opportunities to assist each other unrelated to any federal monies they may or may not have received.

4.3 Internal Factors

The coordination of primary care in Chicago and Cook County is still in its early stages. The amount of cooperation achieved to date is considered extraordinary by Chicagoans steeped in the city's tradition of health politics[17]. However, those interviewed found it difficult to imagine that the system could revert to its former behavior. All expressed a sense of achievement and a sense that they are moving in the right direction: that it took a long time for things to become so bad, and it will take a long time for them to become better. Enthusiasm and dedication of the health care providers, consumers, and community leaders drive the process forward with a spirit that is clearly infectious. But the process of change is just as clearly often tedious and frustrating.

Built-in Self Reflection

One factor which contributes to the coordination project's ability to function effectively is its orientation towards self-reflection and documentation. The IPHCA's Linkage Project manual described in the preceding section is, in itself, evidence of a focus on learning from experience and documenting these lessons **for planning. The need for** such documentation was anticipated by the planners of HCLP, perhaps anticipating the skepticism of a City and County historically divided by competition and suspicion. As trust builds gradually, incrementally, among those participating in these efforts, such documentation is important to keep all parties focused on their goals, and to remind them how far they have come. Documentation of lessons learned provides for a basis to build consensus among the planning and oversight groups as to what is needed.

Crediting and Building Upon Prior Historical Initiative and Leadership

The initiative of the Chicago Community Trust was a catalyst for much of the activity in building toward a system to coordinate primary care, and a number of individuals took leadership roles to move these efforts forward. These efforts have become part of the recognized history of the effort and as new leadership has emerged, the

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17 **The Project Officer from the Chicago Community Trust characterized the history of health planning in the city: "There is no health policy in Chicago -- only health politics."**

culture of these efforts has evolved to grant recognition and appreciation for each party's contribution. Care has also been taken to recognize and build on the accomplishments of each project or effort. This inclusive approach differs dramatically from the prior culture of competition that characterized the health care system in the city and county. The new culture of cooperation is being carefully nurtured by key participants. Proposals for new initiatives carefully document their relationship to and roots in prior efforts.

Institutionalizing Lessons Learned from Problem Solving *for* Individual Patients

Systems problems often present themselves on a patient-by-patient basis. The HCLP and related efforts have consciously realized that the solution for one patient produce ideas for systems change that can benefit all patients. The HCLP staff have been on-call to the linkage partners and others to help solve problems, most of which relate to specific patients who are stuck in the system in some way. While the role of staff is frequently to mediate a problem-solving process, it has also evolved to provide the reflection and perspective upon the implications of each situation for the system as a whole. Once a problem is resolved for the individual patient, ideas that emerged out of the problem-solving process are preserved for input to systems planning and broader problem solving efforts.

The Role of a Perceived Neutral Party in Promoting Cooperative Problem Solving

The IPHCA, its Executive Director, and its HCLP staff, while not strictly neutral in terms of their institutional affiliation, succeeded in demonstrating the essential roles of facilitator/mediator/staff to a number of the most visible cooperative efforts. To accomplish this, lead staff demonstrated their ability and availability to listen to all parties. In a City and County without a history of cross-system cooperation, the injection of persons capable of translating the concerns of participants without taking sides has been critical. Further, these individuals modelled behavior that treated each party's perspectives with respect and enabled historically competing or conflicting groups to recognize their common interests.

The IPHCA has also been able to cross-fertilize ideas among the many projects they are involved with. Their credibility with involved organizations makes it possible for them to credibly articulate and recognize the achievements of one group and offer them as suggestions for change for another group without seeming to promote any single organization.

Political ambitions and agendas of individuals would rapidly sabotage these collaborative efforts. The communication of information is easily politicized. The sensitivity of HCLP staff as well as other active participants, to the political environment has helped in supporting balanced decisions, and minimizing conflict among partners.

Adequate Staff Support for Oversight Committee Meetings

Keeping the most senior leadership involved with the collaborative process has been enhanced by demonstrating **a respect for their time by providing timely, well written documentation in support of meetings.** Committee chairpersons must be briefed, agendas developed, and supporting documents prepared. The quality of written materials, and briefings from HCLP staff were identified as making a major contribution to the ability the HCLP Steering Committee to make decisions and move forward as quickly as it has.

Project Tracking and Data Collection *for* Evaluation Purposes

Identifying routinely and easily interpreted data that can be used to measure success was a critical element in preserving initially fragile collaborative efforts and in reinforcing those efforts. The reporting of decreased waiting times for appointments, referral appointments kept, and other information provided immediate feedback as the efficacy of the changes being made. Clinics that were initially cool toward making referrals of their patients to other clinics recognized the immediate benefits to the pregnant patient, for example, of seeing a physician two or three weeks sooner. This type of data helped focus decisions on those aspects of quality and access that all parties could agree upon, minimizing conflict and reinforcing appreciation of each group's contribution to improved patient care.

Maintaining this data collection, however, is far from simple. Ongoing training of clinic staff, who turned over frequently at some sites, was very important. Clinic staff need to be trained in the specifics of handling referrals within the linkage agreement terms, filling out forms, and other routine activities. This process requires monthly visits by HCLP staff to provide training and technical assistance as well as frequent telephone contact. It has also required the careful design of common forms and adaptation of clinic documentation to provide the requisite information so that it is consistent and reliable.

When Relationships Are New and *Fragile, Formal Written Agreements Are Important*

The HCLP Steering Committee identified four major components basic to the linkage agreements and sets of issues within each: financial, operational, quality, and planning/marketing/education. Written agreements have evolved to address many of the issues to facilitate smooth working relationships:

- Financial: compatible fee schedules, joint ventures, group purchasing, and shared ancillary services.
- Operational: formal referral mechanisms, computerized appointment scheduling, compatible medical records, client tracking and follow-up, linkage coordinators, joint staff training.

- Quality: quality assurance mechanisms, compatible treatment protocols, joint credentialing criteria, relationship with medical and allied health schools.

- Planning/Marketing/Education: coordinated planning and marketing, compatible data collection, patient and community education, joint needs assessment.

Committed *Leadership* ***from*** **the** ***Primary*** **Service** Delivery Systems

Credit for the ability to mobilize providers and others to follow-up on the Summit findings and recommendations is granted to the new Commissioner of CDOH, and the new Chief of CCBHS, both distinguished women with long careers of service and leadership in Chicago health care. These two individuals, whose political sophistication, connections, and credibility are viewed as unimpeachable, were cited by most of our informants as essential to the success of moving the City and County systems toward cooperation with each other and with the community health centers.

Considerable recognition was also granted to the IPHCA for its leadership and willingness to serve as the grantee and facilitator for these activities. Admiration was expressed by virtually everyone interviewed for the quiet diligence and skills of the HCLP Project Director and her staff. While the role of the HCLP staff was understood as facilitative, the success of their work made many of their intense and ongoing efforts to mediate among all parties all but invisible. They stuck with it until the problem was solved and then moved on, never requiring any particular recognition for the role they played. Most of those interviewed thought the efforts to coordinate would have been considerably less successful without the efforts of these hard-working individuals,

Consumer *Input* Was Solicited in the Design of Coordination Projects

Coordination leaders are credited with effectively seeking out community participation in the health planning process. Beginning with the Summit, efforts were made to seek grass roots community representatives and ensure that their concerns were heard and addressed. One example of this orientation is reflected in the story told by one interviewee of the Austin community's reaction to the closure of their local hospital, an institution which, she conveyed, represented a symbol of power to the community. The hospital was a place where consumers had their children, spent time with loved ones who were ill, injured or dying: it was a place where "for a couple of days, someone else took care of me". Its closure represented a loss, a sense of abandonment, and a motivating force for local health advocates to mobilize energy to be heard.

This advocate's view of the meaning of health care to a consumer is unusual but suggestive of the type of communication that has the power to move bureaucracies to listen to consumers. She described a broad concept of health: "a health care provider is someone who makes the community healthier." The interviewee then described the efforts of her advocacy group to create a service center across the street from the hospital. In other areas the feedback of community leaders is reflected in the Summit's final recommendations, and their ideas are represented in all aspects of health care coordination efforts.

Consumer groups in Chicago have demonstrated their ability to harness the resources of their people, churches, and other organizations to make contributions to the health care system and to take over responsibility for running some of their own health care institutions. To be effective contributors to the health planning process, however, consumer representatives new to the process may need training to be effective.

The effective involvement of consumer groups in health planning was based on a concept of empowering people in their own communities to make a commitment to health in terms that are meaningful to them. The process of consumer involvement benefits the coordination effort by enabling it to better understand the needs and wants of its consumers and, conversely, benefits the community by inducing it to examine its own health needs and make a commitment to addressing those needs. It also supports efforts to market services to consumers and distribute appropriate messages on the street.

Both **Bottom-up and lop-down Approaches Are Essential**

The bottom-up efforts to build linkages among providers, alone, would not substantively change the Chicago and Cook County health care delivery system and would be fragile without such systems changes. Top-down collaboration itself would also not effect the tangible change needed to engage front line workers in a commitment to change from business as usual. In Chicago and Cook County change is evolving from both directions and is moving forward more rapidly and irreversibly than would otherwise be possible. The Chicago Community Trust Project Officer's view of the accomplishments of efforts to date focus on the emergence of a potential new form of governance for health care systems sewing **poor people. In their view, if the bottom-up accomplishments can be**

supported by this new governance structure evolving through the Ambulatory Care Council, the process of change in their community will be cemented.

Summary

The changes taking place in Chicago and Cook County are the result of the metamorphosis of earlier failures of service providers, policy makers and others to work together into opportunities for collaborative service delivery. The initiative of the Chicago Community Trust and the state and local leadership that conducted the Health Care Summit was based on admission of such a problem. Their engagement of all those with any interest in the problem in developing a plan began a process of broad-based cooperation. The fortuitous change to aggressive new leadership in the City and County health care administrations provided an active commitment to follow through the recommendations from the Summit. The availability of the IPHCA further linked the private CHCs to the other public resources and provided a vehicle to receive grant funds from foundations without entangling those funds or personnel in complex governmental systems.

These changes are taking place clinic-by-clinic and patient-by-patient. The process of change is slow and not very romantic. Lessons can be learned from Chicago's experience both in the specific terms discussed in the HCLP manual and the more general observations of our review team. The experience of Chicago highlights some of the facets that affect coordination in an environment where there are many players and complex health needs and delivery issues.